implementation of the plan of care that meets patient's needs, per re-certification period.

G0180: *Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period.*

G0236 *Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (list separately in addition to code for primary procedure)*

Comment: Individuals have requested that we establish additional G-codes that would specify the use of computer-aided detection with direct digital image mammograms. Currently, the descriptors associated with HCPCS code G0236 (diagnostic) and CPT code 76085 (screening) refer not only to the application of computer-aided detection but also to the conversion of film images to digital images.

Response: When the computer-aided detection codes were originally assigned, we intended that they would be used for the application of computer-aided detection to both direct digital images and to standard film images that were converted to digital images. The current descriptors of both HCPCS code G0236 and CPT code 76085 do not explicitly state that the code can be billed in conjunction with either direct digital images or standard film images converted to digital images. We have revised the descriptor associated with the application of computer-aided detection to diagnostic images (HCPCS code G0236) to incorporate both direct digital images and standard film images converted to digital images. Additionally, we will request that the CPT editorial panel review the current definition associated with the screening computer-aided detection code (CPT code 76085) for future revision. Until such time as a revision is made to CPT code 76085, physicians should use CPT code 76085 for both direct digital screening images as well as for standard film screening images that are converted to digital images.

G0236 is revised to read as follows: *Digitization of film radiographic images with computer analysis for lesion detection, or computer analysis of digital mammogram for lesion detection, and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure).*

G0239 *Therapeutic procedures to improve respiratory function, other than services described by G0237, two or more (includes monitoring).*

For clarity, and to address concerns expressed by individuals about how to code group treatment of patients with procedures described in G0237, we are revising the descriptor for G0239 to read as follows:

G0239 *Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more (includes monitoring).*

Deletion of G Codes

We will be deleting the following G codes for CY 2003: G0002 *Office procedure, insertion of temporary indwelling catheter, foley type (separate procedure)*

Services formerly billed under G0002 will be billed under CPT codes 51702 *Insertion of temporary indwelling bladder catheter; simple (e.g., Foley)* or 51703 *Insertion of temporary indwelling bladder catheter; complicated (e.g., altered anatomy, fractured catheter/balloon).*

G0004 *Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period; includes transmission, physician review and interpretation;* G0005 *Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period; recording (includes hook-up, recording and disconnection);* G0006 *Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period; 24 hour attended monitoring, receipt of transmissions, and analysis;* and G0007 *Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30 day period; physician review and interpretation only.*

Services formerly billed under G0004 will be billed using CPT code 93268, *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; includes transmission, physician review and interpretation;* services billed using G0005 will be billed using CPT code 93270, *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; recording (includes hook-up, recording and disconnection);* services billed using G0006 will be billed using CPT code 93271, *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; monitoring, receipt of transmissions and analysis;* services billed using G0007 will be billed using CPT code 93272 *Patient demand single or multiple event recording with presymptom memory loop, 24-hour attended monitoring, per 30 day period of time; physician review and interpretation only,* and services billed using G0015 will be billed using CPT code 93012 *Telephonic transmission of post-symptom electrocardiogram rhythm strip(s), per 30 day period of time, tracing only.* Unattended monitoring of patient demand single or multiple event recording with presymptom memory loop, per 30 day period of time and unattended telephonic transmission of post symptom electrocardiogram rhythm strip(s), per 30 day period of time should be billed using CPT code 93799, *Unlisted cardiovascular service or procedure.*

G0050 *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound*

Services formerly billed under G0050 will be billed using CPT code 51798.

G0131 *Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)* and G0132 *Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).*

Services formerly billed under G0131 will be billed using CPT code 76070, and those billed under G0132 will be billed using CPT code 76071.

G0185 *Destruction of localized lesion of choroids for example, choroidal neovascularization; transpupillary thermotherapy (one or more sessions)* and G0186 *Destruction of localized lesion of choroids for example, choroidal neovascularization; photocoagulation, feeder vessel technique (one or more sessions).*

Services formerly billed under G0185 will be billed using CPT code 0016T, *Destruction of localized lesion of choroids (e.g., choroidal revascularization), transpupillary thermotherapy,* and G0186 will be billed using CPT code 0017T, *Destruction of macular drusen, photocoagulation.*

G0193 *Endoscopic study of swallowing function (also fiberoptic endoscopic evaluation of swallowing (FEEST)),* G0194 *Sensory testing during endoscopic study of (add-on code) referred to as fiberoptic endoscopic evaluation of swallowing*

with sensory (FEEST), G0195 *Clinical evaluation of swallowing function (not involving interpretation of dynamic radiological studies or endoscopic study of swallowing),* and G0196 *Evaluation of swallowing involving swallowing of radio-opaque materials.*

Services formerly billed under G0193 will be billed using new CPT code 92612; services billed using G0194 will be billed using new CPT code 92614; services billed using G0195 will be billed using new CPT code 92610; and G0196 should be billed using new CPT code 92611.

G0197 *Evaluation of patient for prescription of speech generating devices,* G0198 *Patient adaptation and training for use of speech generating devices,* G0199 *Re-evaluation of patient using speech generating devices,* G0200 *Evaluation of patient for prescription of voice prosthetic,* and G0201 *Modification or training in use of voice prosthetic.*

Services formerly billed under G0197 will be billed using CPT code 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour,* and, if appropriate, CPT code 92608, *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient;* each additional 30 minutes; services billed using G0198 will be billed using CPT code 92609 *Therapeutic services for the use of speech-generating device, including programming and modification;* services billed using G0199 will be billed using CPT code 92607, using the -52 modifier if the service is less than 1 hour; services billed using G0200 will be billed using revised CPT code 92597 *Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech;* and services billed using G0201 will be billed using CPT code 92507.

G0240 *Critical Care Service delivered by a physician; face-to-face, during inter-facility transport of a critically ill or critically injured patient: first 30–74 minutes of active transport,* and G0241—*each additional 30 minutes (list separately in addition to G0240)*

Services formerly billed under G0240 and G0241 will be billed using CPT codes 99289 and 99290.

V. Update to the Codes for Physician Self-Referral Prohibition

A. Background

On January 4, 2001 we published in the **Federal Register** a final rule with comment period, ''Medicare and Medicaid Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships'' (66 FR 856). That final rule incorporated into regulations the provisions in paragraphs (a), (b) and (h) of section 1877 of the Act. Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain ''designated health services'' to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. In the final rule, we published an attachment listing all of the CPT and HCPCS codes that defined the entire scope of the following designated health services for purposes of section 1877 of the Act: clinical laboratory services; physical therapy services (including speech-language pathology services); occupational therapy services; radiology and certain other imaging services; and radiation therapy services and supplies.

In the January 2001 final rule, we stated that we would update the list of codes used to define these designated health services in an addendum to the annual physician fee schedule final rule. The purpose of the update is to conform the code list to the most recent publications of CPT and HCPCS codes. An updated all-inclusive list of codes was included in the November 1, 2001 physician fee schedule final rule in Addendum E and was subsequently corrected in a notice that was published in the **Federal Register** (66 FR 20681) on April 26, 2002.

The updated all-inclusive list of codes effective for January 1, 2003 is presented in Addendum E in this final rule. It is our intent to always use Addendum E of the annual physician fee schedule final rule for the physician self-referral update. The updated all-inclusive list of codes will also be available on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.*

B. Response to Comments

We received three comments regarding the code list. The comments and our responses are stated below.

Comment: One commenter agreed with the additions and deletions to the list of designated health services as published in the November 1, 2001 physician fee schedule final rule (66 FR 55312). The commenter expressed the understanding that we would address the comments regarding the original list of designated health services (published in the January 4, 2001 final rule) in a second final rule on the physician self-referral prohibition. A second commenter raised concerns about our decision (announced in the January 4, 2001 final rule) to exclude nuclear medicine from the definition of ''radiology and certain other imaging services.''

Response: The first commenter is correct in understanding that we intend to address substantive comments on the designated health services that are defined by reference to HCPCS and CPT codes in a second final rule concerning the physician self-referral prohibition. We will also address the second commenter's concerns regarding nuclear medicine in that final rule. As noted above, this update to the code list merely reflects changes to the most recent publications of HCPCS and CPT codes.

Comment: One commenter noted that we post on our Web site (*http://www.hcfa.gov/stats/cpt/rvudown.htm*) an Excel spreadsheet file containing all of the CPT/HCPCS codes with accompanying RVUs. The commenter suggested that we add a column indicating whether a code is considered a designated health service for purposes of the physician self-referral law, as well as in which category of designated health services it would be included. The commenter stated that, as changes are made, they would be scattered throughout several physician fee schedules.

Response: We believe that the commenter was concerned that updates to the list of designated health services under the physician self-referral law would be published in various fee schedules throughout the course of a year. This is not the case. We publish the annual update and the entire list of CPT/HCPCS codes in the physician fee schedule final rule. (Addendum E contains the updated all-inclusive list of codes.) We have no plans to publish an updated list of codes for physician self-referral purposes in any other fee schedule. We chose the physician fee schedule, as opposed to one of the other fee schedules, because we believe that physicians would be more likely to see it. We maintain a current list of codes used to define certain designated health services for purposes of the physician self-referral law on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.* We have decided not to make any changes to the RVU website at this time because we believe the updated all-inclusive list of codes used for purposes of physician self-referral is readily available to all physicians.

C. Revisions Effective for 2003

Table 9, below, identifies the additions and deletions to the comprehensive list of physician self-referral codes published in Addendum

E of the November 2001 physician fee schedule final rule and subsequently corrected in the April 26, 2002 correction notice (66 FR 20681). Table 9 also identifies the additions, deletions and revisions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an end-stage renal dialysis (ESRD) facility) and in § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

We will consider comments with respect to the codes listed in Table 9 below, if we receive them by the date specified in the **DATES** section of this final rule.

TABLE 9.—ADDITIONS AND DELETIONS TO THE PHYSICIAN SELF-REFERRAL CODES

HCPCS	CPT [1]/Descriptor
Additions:	
51798	Us urine capacity measure
76070	Ct bone density, axial
76071	Ct bone density, peripheral
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus
76812	Ob us, detailed, addl fetus
92601	Cochlear implt f/up exam < 7
92602	Reprogram cochlear implt < 7
92603	Cochlear implt f/up exam 7 >
92604	Reprogram cochlear implt 7 >
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
0010T	TB test, gamma interferon
0019T	Extracorp shock wave tx, ms
0020T	Extracorp shock wave tx, ft
0023T	Phenotype drug test, HIV 1
0026T	Measure remnant lipoproteins
0028T	Dexa body composition study
0029T	Magnetic tx for incontinence
0030T	Anitprothrombotin antibody
0041T	Detect UR infect agnt w/cpas
0042T	Ct perfusion w/contrast, cbf
0043T	Co expired gas analysis
G0256	Prostate brachy w palladium
G0261	Prostate brachytherapy w/rad
G0262	Sm intestinal image capsule
G0274	Radiopharm tx, non-Hodgkins
G0279	Excorp shock tx, elbow epi
G0280	Excorp shock tx other than
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0288	Recon, CTA for surg plan
J0636	Inj calcitriol per 0.1 mcg
J1756	Iron sucrose injection
J2501	Paricalcitol
J2916	Na ferric gluconate complex
Q3021	Ped hepatitis b vaccine inj
Q3022	Hepatitis b vaccine adult ds
Q3023	Injection hepatitis Bvaccine
Deletions:	
76830	Us, exam transvaginal
76872	Echo exam, transrectal
76873	Echograp trans r, pros study
86915	Bone marrow/stem cell prep
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im
92510	Rehab for ear implant
97014	Electric stimulation therapy
G0026	Fecal leukocyte examination
G0027	Semen analysis
G0050	Residual urine by ultrasound
G0131	CT scan, bone density study
G0132	CT scan, bone density study
G0193	Endoscopicstudyswallowfunctn

TABLE 9.—ADDITIONS AND DELETIONS TO THE PHYSICIAN SELF-REFERRAL CODES—Continued

HCPCS	CPT [1]/Descriptor
G0194	Sensorytestingendoscopicstud
G0195	Clinicalevalswallowingfunct
G0196	Evalofswallowingwithradioopa
G0197	Evalofptforprescipspeechdevi
G0198	Patientadapation&trainforspe
G0199	Reevaluationofpatientusespec
G0200	Evalofpatientprescipofvoicep
G0201	Modifortraininginusevoicepro
J0635	Calcitriol injection
J1755	Iron sucrose injection
J2915	NA Ferric Gluconate Complex
Revisions:	
76085	Computer mammogram add-on [when used in conjunction with 76092]

[1] CPT codes and descriptions only are copyrighted in the 2002 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

The ''Additions'' section of Table 9 generally reflects new CPT and HCPCS codes that become effective January 1, 2003. The one exception is the addition of the following emerging technology codes, referred to as Category III codes, which the AMA first included in the CPT effective January 1, 2002: 0010T, 0019T, 0020T, 0023T, and 0026T. CPT codes 0010T, 0023T, and 0026T represent clinical laboratory services while CPT codes 0019T and 0020T are therapy codes. These codes were addressed in the November 2001 physician fee schedule final rule with the clarification that coverage and payment of these services is generally at the discretion of the carrier. However, the portion of the November 2001 final rule that concerned the list of codes for physician self-referral purposes failed to address these new codes. Thus, we are adding the Category III codes that should have been included in last year's update. We also are adding the following new Category III codes issued for 2003 to which the physician self-referral prohibition applies: 0028T, 0029T, 0030T, 0041T, 0042T, and 0043T. CPT codes 0028T and 0042T are radiology services; CPT code 0029T is a physical therapy service; and, CPT codes 0030T, 0041T and 0043T are clinical laboratory services.

Table 9 also reflects the addition of 4 new codes (J0636, J1756, J2501 and J2916) to the list of dialysis-related outpatient prescription drugs that may qualify for the exception described in § 411.355(g) regarding those items. The physician self-referral prohibition will not apply to these drugs if they meet the conditions set forth in § 411.355(g). Table 9 also reflects the addition of 3 vaccine codes (Q3021, Q3022 and Q3023) to the list that identifies preventive screening tests, immunizations and vaccines that may qualify for the exception described in § 411.355(h) for such items and services. The physician self-referral prohibition will not apply to these vaccines if they meet the conditions set forth in § 411.355(h) concerning the exception for preventive screening tests, immunizations, and vaccines.

With the exception of CPT codes 76830, 76872 and 76873 for ultrasounds, the ''Deletions'' section of Table 9 reflects changes necessary to conform the code list to the most recent publications of CPT and HCPCS codes. We are deleting CPT code 76830 for transvaginal ultrasound and CPT codes 76872 and 76873 for transrectal ultrasounds because these codes should never have appeared on the list of designated health services. Our definition of ''radiology and certain other imaging services'' published in the January 2001 final rule (66 FR 956) specifically excludes any ultrasonic procedure that requires ''the insertion of a needle, catheter, tube, or probe''. Thus, although the deletion of these codes is not a change to conform to an annual change in CPT or HCPCS codes, we are making the change at this time so that the list of codes will accurately reflect the regulatory definition for ''radiology and certain other imaging services.''

Table 9 includes one revised CPT code. That is CPT code 76085, ''Computer mammogram add-on.'' In the CPT publication effective January 1, 2003, the CPT long descriptor was changed to delete the word ''screening'' so that the digitization no longer refers only to screening mammography. Because our exception under § 411.355(h) applies to preventive screening tests, we have revised the list of codes that may qualify for that exception to indicate that CPT code 76085 may qualify for the exception only when it is used in conjunction with CPT code 76092, ''Mammogram screening.''

VI. Physician Fee Schedule Update for Calendar Year 2003

A. Physician Fee Schedule Update

The physician fee schedule update is determined under a calculation methodology that is specified by statute. Under section 1848(d)(4) of the Act, the update is equal to the product of 1 plus the percentage increase in the Medicare Economic Index (MEI) (divided by 100) and 1 plus the update adjustment factor. For CY 2002, the MEI is equal to 3.0 percent (1.030). The update adjustment factor is equal to –7.0 percent (0.930). Section 1848(d)(4)(F) of the Act requires an additional –0.2 percent (0.998) reduction to the update for 2003. Thus, the product of the MEI (1.030), the update adjustment factor (0.930), and the statutory adjustment factor (0.998) equals the CY 2003 update of –4.4 percent (0.956).

The Department believes that the negative update is inappropriate because the current update system does not reflect actual, after the fact, data from earlier years. Instead, the Act requires the Department to rely upon estimates made in past years, even though the Department now has actual data for these particular years. Even though after-the-fact data show that for certain years actual increases differed to some degree from earlier estimates, the Department is unable to revise estimates without congressional action. We have exhaustively searched for a different interpretation of law that would allow us to revise estimates for earlier years administratively, but unfortunately, we had to conclude that current law does not permit such an interpretation.

Without congressional action to address the current legal framework, the Department is compelled to announce a

physician fee schedule update for CY 2003 of –4.4 percent. The Department's calculations are explained below.

We have, however, also identified reasonable adjustments that could result in a positive update in physician fee schedule rates if the Department were permitted by law to make those adjustments. Revisions of estimates used to establish the sustainable growth rates (SGR) for fiscal years (FY) 1998 and 1999 and Medicare volume performance standards (MVPS) for 1990 through 1996 could, under present estimations, result in an increase in the update.

The Department intends to work closely with the Congress to develop legislation that could permit a positive update, and hopes that such legislation can be passed before the negative update takes effect. Because the Department wishes to take action immediately in the event that Congress provides the Department legal authority to make the corrections, we are requesting comments regarding how physician fee schedule rates could and should be recalculated prospectively in the event that Congress provides the Department with legal authority to revise estimates used to establish the sustainable growth rates (SGR) for FYs 1998 and 1999 and the MVPS for 1990–1996.

B. The Percentage Change in the Medicare Economic Index

1. Medicare Economic Index (MEI) Productivity Adjustment

In the June 28, 2002 proposed rule, we reviewed the history of the MEI productivity adjustment, described the current MEI productivity adjustment, identified and evaluated possible alternative MEI productivity adjustments based on the individual contributions we solicited from experts on this topic, and proposed changing the MEI productivity adjustment to reflect an economy-wide multifactor productivity adjustment. In this final rule, we repeat this research information, respond to public comments on the MEI, and determine the CY 2003 MEI using the proposed methodological change.

a. History of MEI Productivity Adjustment

The MEI is required by section 1842(b)(3)(L) of the Act which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by year-to-year economic changes. S. Rep. No. 92–1230, at 191 (1972) provides slightly more detail on that index, stating that:

Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels combined in a manner consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group.

Consistent with section 1842(b)(3)(L) and legislative intent, in 1975, we determined that the MEI would be based on a broad wage measure reflecting overall earnings growth, rather than direct inclusion of physicians' net income. We used average weekly earnings of nonagricultural production (non-supervisory) workers, net of worker's productivity, as the wage proxy in the initial MEI. We included the productivity adjustment because it avoided double counting of gains in earnings resulting from growth in productivity and produced an MEI that approximated an economy-wide output price index similar to the Consumer Price Index (CPI). The productivity adjustment we used was the annual change in economy-wide private non-farm business labor productivity, applied only to the physicians' earnings portion of the MEI (then 60 percent).

As noted, the productivity adjustment in the MEI serves to avoid the double counting of productivity gains. Absent the adjustment, productivity gains from producing additional outputs (procedures) with a given amount of inputs would be included in both the earnings component of the MEI (reflecting growth in overall economy-wide wages) and in the additional procedures that are billed (reflecting physicians' own productivity gains). Therefore, general economic labor productivity growth is removed from the labor portion of the MEI.

Although the basic structure of the MEI remained relatively unchanged from its effective date (July 1, 1975) until 1992, its weights were updated periodically and a component was added for professional liability insurance. Section 9331 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA 86) mandated that we conduct a study of the structure of the MEI and prepare a notice and offer the public an opportunity to comment before we revise the methodology for calculating the MEI. Based on this requirement, we held a workshop with experts on the MEI in March 1987 to discuss topics ranging from the specific type of index to use (Laspeyres versus Paasche) to revising the method of reflecting productivity changes. Participants included the Federal government, the Physician Payment Review Commission (PPRC), the Congressional Budget Office, the AMA, and several private consulting firms. The meeting participants concluded that a productivity adjustment in the MEI was appropriate and that an acceptable measure of physician-specific productivity did not currently exist. Many alternative approaches were discussed, including the use of a policy-based ''target'' measure and several existing economic productivity measures.

Using recommendations from the meeting participants, we revised the MEI and the productivity adjustment with the implementation of the physician fee schedule as discussed in the November 1992 final rule (57 FR 55896). While we retained an adjustment for economy-wide labor productivity, this adjustment was applied to all of the direct labor categories of the MEI (70.448 percent), not just physicians' earnings, and was based on the 10-year moving average percent change (instead of annual percent changes). This form of the index has been used since that time, and was most recently discussed in the November 1998 final rule (63 FR 58845) when the MEI weights were rebased to a 1996 base year.

The BBA replaced the Medicare Volume Performance Standard (MVPS) with a Sustainable Growth Rate (SGR). The SGR is an annual growth rate that applies to physicians' services paid for by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased. Specifically, the SGR is calculated on the basis of the weighted average percentage increase in fees for physicians' services, growth in fee-for-service Medicare enrollment, growth in real per capita Gross Domestic Product (GDP), and the change in expenditures on physicians' services resulting from changes in law or regulations.

When the SGR was enacted, the Congress specified continued use of the MEI. By 1997, the MEI, including its productivity adjustment, had been used in updating Medicare payments to physicians for over twenty years. We did not propose any changes to the productivity adjustment used in the MEI when the SGR system was enacted because its continued use was consistent with the newly mandated formula. If we did not make a productivity adjustment in the MEI, general economic productivity gains would be reflected in two of the SGR factors, the MEI and real per-capita GDP (which reflects real GDP per hour worked, or labor productivity, and hours worked per person). We believe it is reasonable to remove the effect of general economic productivity from one of these factors (the MEI) to avoid double counting.

As noted previously, since its original development, the MEI productivity adjustment has been based on economy-wide productivity changes. This practice arose from the fact that the physicians' compensation portion of the MEI is proxied to grow at the same rate as general earnings in the overall economy, which reflect growth in overall economy-wide productivity. Removing labor productivity growth reflected in general earnings from the labor portion of the MEI produces an index that is consistent with other economy-wide output price indexes, like the CPI.

b. Research on Alternative MEI Productivity Adjustments

In the June 2002 proposed rule we presented the research we completed on evaluating the most appropriate productivity adjustment for the MEI. This research included evaluating the currently available productivity estimates produced by the BLS to develop a better understanding of the strengths and weaknesses of these measures and reviewing the theoretical foundation of the MEI to understand how labor and multifactor productivity relate to the current physician payment system. We also studied the limited publicly available data to begin to develop preliminary estimates of trends in physician-specific productivity to better understand the current market conditions facing physicians. Finally, we solicited the individual contributions of academic and other professional economic experts on prices and productivity. These experts included individuals from the MedPAC, the AMA, the Office of Management and Budget (OMB), Dr. Uwe Reinhardt from Princeton University, Dr. Joe Newhouse from Harvard University, Dr. Ernst Berndt from MIT, and Dr. Joel Popkin from Joel Popkin and Company. Below we repeat the findings on each of the six options we investigated and detailed in the proposed rule:

- Option 1—Using a physician-specific productivity adjustment.

This option would entail using an estimate of physician-specific productivity to adjust the MEI. This option may have some theoretical attractiveness, but there are major problems in obtaining accurate measures of physician-specific productivity. First, no published measure of physician-specific productivity is available. The Federal agency that produces the official government statistics on productivity, BLS, does not calculate or publish productivity measures for any health sector. Nor are there alternative measures of physician-specific productivity that would conform to the BLS methodology for measuring productivity. Second, it is not clear that using physician-specific productivity within the current structure of the MEI would be appropriate. Because we believe the MEI appropriately uses an economy-wide wage measure as the proxy for physician wages, using physician specific productivity could overstate or understate the appropriate wage increases in the MEI.

We do believe, however, that it is important to understand the rate of change in physician-specific productivity. Toward this end, we have performed our own preliminary analysis of physician-specific productivity, using the limited available data on physician outputs and inputs. Our analysis attempted to simulate the methodology the BLS would use to measure productivity. To help achieve this we have been in contact with experts at the BLS to obtain their feedback on our methodology. While this information cannot be interpreted as an official measure of physician productivity, we do believe it provides a rough indication of the current market conditions facing physicians. We used this information to aid in forming our determination of the most appropriate productivity adjustment to incorporate in the MEI, fully recognizing its preliminary nature and other limitations of our analysis. The results of our preliminary analysis suggest that long-run physician-specific productivity growth is currently near the level of economy-wide multifactor productivity growth. Prior to the recent period, however, our preliminary estimates suggested that physician productivity gains were generally significantly greater than general economy-wide multifactor productivity gains and more in line with economy-wide labor productivity.

As we have emphasized, our rough estimates are inadequate for establishing a formal basis for the productivity adjustment to the MEI. In addition, the underlying economic theory is not sufficiently compelling, at this time, to adopt a physician-specific productivity measure, even if a suitable one were available. We conclude, however, that economy-wide multifactor productivity growth appears to be roughly comparable to our estimates of current physician-specific productivity growth.

Comment: A few commenters urged us to develop a measure of productivity that more accurately reflects the conditions facing physicians. The commenters suggested that we consider issues like increased regulatory burden on physicians and the service-oriented nature of physician services.

Response: As we stated in the June 2002 proposed rule and repeated above, no publicly available measure of physician productivity exists. In addition, no publicly available measure of service-sector productivity exists. Because of this it is not possible at this time to incorporate a productivity adjustment in the MEI that explicitly reflects physician marketplace characteristics.

However, we do believe that it is important that the productivity adjustment included in the MEI be consistent with the market conditions facing physicians. As we have discussed in this final rule, we attempted to understand the trends in physician productivity by researching and making the most optimal use of the sparse data available. We will continue to refine this research, including soliciting contributions both from experts at BLS and outside experts on measuring productivity. In addition, we encourage the commenters to work with BLS to pursue the development of official measures of physician and health sector productivity.

- Option 2—Using economy-wide labor productivity applied to the labor portion of the MEI.

We have applied economy-wide labor productivity growth to a portion of the MEI in some form since the inception of the index in 1975. For the 2002 update, we applied the 10-year moving average percent change in economy-wide labor productivity to the labor portion of the MEI. This adjustment was developed based on the contributions of a 1987 expert panel. That panel concluded that applying labor productivity data to the labor portion of the index was a technically sound way to account for

productivity in the physician update. This method made optimal use of the available data because labor productivity data were, and are, available on a more-timely basis than economy-wide multifactor productivity. By applying this measure to the labor portion of the index, the mix of physician-specific labor and non-labor inputs is reflected. Also, the use of a 10-year moving average percentage change reduces the volatility of annual labor productivity changes.

Our research, however, has indicated that using multifactor productivity applied to the entire index is a superior method to using an economy-wide labor productivity measure applied only to the labor portion of the index. The experts with whom we consulted believed it was more appropriate to reflect the explicit contribution to output from all inputs. The current measure explicitly reflects the changes in economy-wide labor inputs but does not reflect the actual change in non-labor inputs. Instead, it implicitly assumes that non-labor inputs would grow at a rate necessary to produce an economy-wide multifactor measure that is equivalent to the current MEI productivity adjustment. That implicit assumption is less precise than a direct, explicit calculation.

In addition, while the implicit approach produced an MEI productivity adjustment in most years that was reasonably consistent with overall multifactor productivity growth, it now appears less consistent with the actual change in non-labor inputs in the economy. In recent years, economy-wide labor productivity has grown very rapidly. This acceleration is partly the result of major investments in non-labor inputs that have helped to create a more productive work force. Also, the Bureau of Economic Analysis (BEA) adopted methodological changes in accounting for computer software purchases in measuring GDP. These changes have significantly increased the measured historical growth rates in real GDP and labor productivity. As a result of these developments, the current MEI productivity adjustment, applying labor productivity only to the labor portion of the MEI, has increased very rapidly. Because the multifactor definition is an explicit calculation of the change in economic output relative to the change in both labor and non-labor inputs, it better reflects the overall productivity trend changes.

Finally, as noted previously, our preliminary estimates of physician-specific productivity suggest a current growth pattern that is similar to growth in multifactor productivity in the economy overall. In consideration of the economic theory underlying productivity measurement, especially in view of the recent developments in labor versus non-labor economic input growth trends, we concluded that using a multifactor productivity adjustment is superior to the current methodology for adjusting for productivity in the MEI.

• Option 3—Change to using economy-wide multifactor productivity.

The option we proposed in the June 2002 proposed rule was to adjust for productivity gains in the MEI using economy-wide multifactor productivity applied to the entire index, instead of labor productivity applied to the labor portion of the MEI. This option would better satisfy the theoretical requirements of an output price, in this case the MEI, by explicitly reflecting the productivity gains from all inputs. In addition, the use of economy-wide multifactor productivity would still be consistent with the MEI's use of economy-wide wages as a proxy for physician earnings. While annual multifactor productivity can fluctuate considerably, though usually less than labor productivity, using a moving-average would produce a relatively stable and predictable adjustment.

Each expert with whom we consulted believed that using a multifactor productivity measure was theoretically superior to the previous methods used to adjust the MEI because it reflects the actual changes in non-labor inputs instead of reflecting an implicit assumption about those changes. These experts also believed that the lack of timely data on multifactor productivity was not as important as would have appeared initially. Instead, they believed it was more appropriate that the adjustment be based on a long-run average that was stable and predictable rather than on annual changes in productivity. Thus, if a long-run average were used, the increased lag time associated with the availability of published data on multifactor productivity becomes less significant. Finally, one expert believed that changing to economy-wide multifactor productivity applied to the entire MEI would make it easier to understand the magnitude of the productivity adjustment.

However, use of multifactor productivity to adjust the MEI poses two concerns. First, multifactor productivity is much harder to measure than labor productivity. Economic inputs other than labor hours can be very difficult to identify and calculate properly. The experts at BLS, however, have adequately overcome these difficulties, and we are satisfied that their official published measurements are sound for the purpose at hand. Moreover, use of a 10-year moving average increase helps to mitigate any remaining measurement variation from year to year.

The second concern relates to the timeliness of the data. BLS publishes multifactor productivity levels and changes annually (as opposed to the quarterly release of labor productivity data) and with an extended time lag (about 1½ years). These timeframes arise unavoidably from the difficulties of measuring non-labor input as mentioned above, but would result in a misalignment of the data periods for the data used to adjust the MEI and of the historical data on wages and prices underlying the MEI. For the CY 2003 physician payment update, for example, we would use data on wages and prices through the second quarter of CY 2002, but would have to use multifactor productivity data through CY 2000. Although the misalignment of data periods is a concern, we believe it is a reasonable trade-off in view of the improvement offered by an explicit measurement of non-labor inputs. Also, because use of a 10-year moving average is intended to reduce fluctuations and provide a more stable level of the productivity adjustment, availability of the most recent data is of less importance.

The 10-year moving average percent change in economy-wide multifactor productivity that would be used for the CY 2003 update (historical data through CY 2000) is estimated at 0.8 percent. Our preliminary internal analysis of physician-specific productivity gains suggests that these economy-wide multifactor measures are consistent with those trends. Thus, using economy-wide multifactor productivity for MEI productivity adjustment theoretically would be superior to using labor productivity growth applied to the labor portion of the MEI.

• Option 4—Change to using economy-wide multifactor productivity with physician-specific input weights

Another option we explored was using economy-wide labor and capital productivity measures (which, when weighted together, produce multifactor productivity), but with physician-specific input weights. This method would better reflect the proportion of labor and capital inputs used by physicians, and reflect the explicit contribution to productivity of labor and non-labor inputs. The experts with whom we discussed this option thought it was theoretically consistent with a measure of multifactor productivity, even though different productivity

measures would be applied to different components of the MEI.

A weakness of this method is that the BLS capital productivity series is not widely used or cited; therefore, we are unsure of the accuracy and reliability of this measure. This method also adds another layer of complexity to the formula, making it more difficult to understand the adjustment. We would prefer that any method we choose be straightforward so that it can be readily understood. Moreover, the labor and capital shares for the overall economy do not appear to vary enough from the physician-specific shares in the MEI to result in a significantly different measure. Overall, we believe that this method does not provide enough of a technical improvement to justify the added complexity that would be required to implement it.

• Option 5—Adjusting productivity using a ''Policy Standard''.

In its March 2002 Report to the Congress, MedPAC suggested establishing a policy target for the productivity adjustment. Under this methodology, the level of the policy target would be based on the productivity gains that physicians could reasonably be expected to attain. This level would be set through policy and would likely be based on a long-run average of either economy-wide labor or multifactor productivity (but could reflect other, possibly judgmental, factors). Generally, the level of the policy standard would remain constant for several years, and periodically would be reviewed and adjusted as needed.

Some of the experts we consulted believed that a policy target would lessen the volatility of the adjustment because the target would not be changed often. Conversely, others noted the large, abrupt changes that could result if actual economic performance deviated from the policy standard requiring subsequent adjustments to the standard. Some believed that this method adjusts for the problem of precisely measuring productivity. If we used a policy standard we could avoid having to develop an exact measure. Using a policy target, however, may appear arbitrary without a theoretical basis to support its use.

The policy target recommended by the MedPAC was 0.5 percentage points per year. The MedPAC's justification for this number was that the long-run average of economy-wide multifactor productivity was close to 0.5 percent (the most recent 10-year average is now 0.8 percent). We do not believe this is a preferred option for adjusting the MEI for productivity improvements. Our preference is to use a data based approach that automatically reflects changes in actual economic performance over time, and not through abrupt periodic, possibly large adjustments. Thus, we conclude that a policy target does not provide an improvement over any of the data based methodologies.

Comment: One commenter recommended the productivity adjustment be removed from the MEI to make the index more consistent with our other market baskets.

Response: Since its inception in 1975 the MEI has included a productivity adjustment. By including the productivity adjustment in the MEI and using a general earnings proxy for physician wages, the index approximated an economy-wide output price index like the CPI. This original intent was different from that for the other market baskets, which are defined to reflect pure price changes in inputs associated with providing care. Thus, the MEI appropriately includes an adjustment for productivity changes.

As we described earlier, practically it makes no difference whether productivity is adjusted for within or outside the MEI, as long as an adjustment is present. However, given the historical precedent regarding the definition of the MEI, the apparent legislative intent behind recent legislation that did not prescribe a change to the MEI definition, and the specific update formula that must be used under the SGR, we do not believe it would be appropriate for the productivity adjustment to be made outside the MEI.

• Option 6—Eliminate Productivity Adjustment from the MEI.

Questions are raised occasionally as to the possibility of eliminating the productivity adjustment from the MEI. We did not consider this to be a viable option. Our research concluded that adjusting for productivity in the MEI is necessary in order to have a technically correct measure of an output price increase, free from double-counting of the impact of productivity. Every expert with whom we consulted agreed that a productivity adjustment is appropriate. They believed that the important question is which measure is the most appropriate for the adjustment.

c. Use of a Forecasted MEI and Productivity Adjustment

In a March 2002 Report to the Congress, the MedPAC recommended the use of a forecasted MEI value, rather than the current historical increase. However, implementation of this option raises several legal as well as practical issues. The 1972 Senate Finance Committee report language reflects the intent of the Congress that the MEI should ''follow rather than lead'' overall inflation. As a result, updates to the physician fee schedule have always been based on historical, rather than forecasted, MEI data. In this way, increases in the MEI do not lead the current measures of inflation but follow them based on historical trends. Furthermore, at the time of implementation of the SGR system, the Congress specified that the SGR system should use the MEI that existed at the time, which was based on historical data measures. The law did not recommend or specify a change in the MEI methodology. Thus, the assumption is that the Congress was satisfied that the MEI was functioning as designed. If we were to use a forecasted MEI and productivity adjustment, there are several practical issues that would need to be addressed. One issue is that a change from a historical-based MEI to a projected MEI would cause transitional problems because there would be a period of data that would not be accounted for in the year of implementation. For example, the CY 2002 MEI update was based on historical data through the second quarter of 2001. If we were to use a forecasted MEI in the update for CY 2003, any changes between the second quarter of 2001 and the first quarter of 2003 would not be accounted for in the update. Additionally, changing to a forecasted MEI and productivity adjustment raises additional questions about correcting for forecast errors. Based on these problems, we will continue to use historical data to make updates under the physician fee schedule.

Comment: One commenter urged us to use a forecast of the MEI change for the update in the upcoming year. The commenter believed that we had the legal authority to make such a change and that the transition issues cited in the proposed rule were not relevant.

Response: We do not believe that it would be appropriate to use a forecast of the MEI for the 2003 update. Since the inception of the MEI, and more recently the implementation of the physician fee schedule, the MEI increase for the upcoming year's update has been based on as much historical data as is available when the update is determined. For the 2003 update this means using data that is available through June 2002.

Our interpretation of the legislative intent is for the MEI update to be based on historical data, and does not contemplate a MEI based on projections.

As we stated above, the MEI update has always been based on historical data and we believe that the legislative intent when the SGR system was implemented was to continue using this methodology. In addition, we believe that the transition and forecast error issues described above are legitimate concerns that, at this time, would outweigh the benefits of making such a change. Therefore, we will continue to use historical data in developing the MEI used for the 2003 fee schedule update.

d. Productivity Adjustment to the MEI

Based on the research we conducted on this issue, we are changing the methodology for adjusting for productivity in the MEI. The MEI used for the CY 2003 physician payment update will reflect changes in the 10-year moving average of private non-farm business (economy-wide) multifactor productivity applied to the entire index. Several commenters agreed with this methodological change.

We made this change because—(1) It is theoretically more appropriate to explicitly reflect the productivity gains associated with all inputs (both labor and nonlabor); (2) the recent growth rate in economy-wide multifactor productivity appears more consistent with the current market conditions facing physicians, and (3) the MEI still uses economy-wide wage changes as a proxy for physician wage changes. We believe that using a 10-year moving average change in economy-wide multifactor productivity produces a stable and predictable adjustment and is consistent with the moving-average methodology used in the existing MEI. Thus, the productivity adjustment will be based on the latest available actual historical economy-wide multifactor productivity data, as measured by the BLS.

We currently estimate the MEI to increase 3.0 percent for CY 2003. This is the result of a 3.8 percent increase in the price portion of the MEI, adjusted downward by a 0.8 percent increase in the 10-year moving average change in economy-wide multifactor productivity. Table 10 shows the detailed cost categories of the MEI update for CY 2003.

TABLE 10.—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2003 [1]

Cost categories and price measures	1996 Weights [2]	CY 2003 percent changes
Medicare Economic Index Total, productivity adjusted	n/a	3.0
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector	n/a	0.8
Medicare Economic Index Total, without productivity adjustment	100.0	3.8
1. Physician's own time [3]	54.5	3.9
a. Wages and Salaries: Average hourly earnings private nonfarm	44.2	3.7
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm	10.3	5.0
2. Physician's practice expense [3]	45.5	3.6
a. Nonphysician employee compensation	16.8	4.2
1. Wages and Salaries: Employment Cost—Index, wages and salaries, weighted by occupation	12.4	3.7
2. Fringe Benefits: Employment Cost—Index, fringe benefits, white collar	4.4	5.5
b. Office Expense: Consumer Price Index for urban consumers (CPI–U), housing	11.6	2.8
c. Medical Materials and Supplies: Producer Price Index (PPI), ethical drugs/PPI, surgical appliances and supplies/CPI–U, medical equipment and supplies (equally weighted)	4.5	2.0
d. Professional Liability Insurance: CMS professional liability insurance survey [4]	3.2	11.3
e. Medical Equipment: PPI, medical instruments and equipment	1.9	1.5
f. Other professional expense	7.6	1.8
1. Professional Car: CPI–U, private transportation	1.3	2.3
2. Other: CPI–U, all items less food and energy	6.3	2.6

[1] The rates of historical change are estimated for the 12-month period ending June 30, 2002, which is the period used for computing the calendar year 2003 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 19, 2002.

[2] The weights shown for the MEI components are the 1996 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for calendar year 1996. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 1996 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics Web site *http://stats.bls.gov.*

[4] Derived from a CMS survey of several major insurers (the latest available historical percent change data are for the period ending second quarter of 2002).

n/a Productivity is factored into the MEI compensation categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

Comment: Several commenters requested that we ensure that the costs of medical liability insurance are adequately reflected in the MEI by making available all information that is the basis for measuring medical liability costs in the MEI.

Response: We agree with the commenters that it is vital that the MEI accurately reflect the price changes associated with professional liability costs. Accordingly, we continue to incorporate into the MEI a price proxy that accomplishes this goal by making the maximum use of available data on professional liability premiums. Below we describe in more detail the annual CMS data collection from commercial insurance carriers, which are designed to maximize the use of publicly available data.

Each year, we solicit professional liability premium data for physicians from a small sample of commercial carriers. This information is not collected through a survey form, but instead is requested from a few national commercial carriers via letter. The carriers provide information on a voluntary basis, and generally between 5 and 8 carriers volunteer this information.

As we require for our other price proxies, the professional liability price proxy must reflect the pure price change associated with this particular cost category. Thus, it should not capture changes in the mix or level of liability coverage. To accomplish this result, we

obtain premium information from commercial carriers for a fixed level of coverage, currently $1 million per occurrence and a $3 million annual limit. This information is collected for every state by physician specialty and risk class. Finally, the state-level, physician-specialty data is aggregated by effective premium date to compute a national total using counts of physicians by state and specialty as provided in the AMA publication ''Physician Characteristics and Distribution in the U.S.''

The resulting data provides a quarterly time series, indexed to a base year consistent with the MEI, which reflects the national trend in the average professional liability premium for a given level of coverage. From this series, quarterly and annual percent changes in professional liability insurance are estimated for inclusion in the MEI. This data produced an 11.3 percent increase for professional liability insurance in the MEI for the 2003 update. We believe that, given the limited timely data available on professional liability premiums, this methodology adequately reflects the price trends facing physicians.

Comment: One commenter urged CMS to use the most current professional liability insurance data available when developing the MEI update.

Response: The professional liability data used to develop the 2003 MEI update was based on premium rates effective as of June 2002. We believe our methodology ensures that the MEI update includes the most recent data available. In the spring of 2002 we collected professional liability insurance premiums from commercial insurers as described in the previous comment. These data included both the premium amount and effective date, which we use to create a quarterly time series. Thus, the professional liability insurance component of the 2003 MEI update includes effective premium rates through the 2nd quarter of 2002, which is consistent with the timeliness of other data used in determining this update.

The most comprehensive data on professional liability costs exist with the state insurance commissioners. However, these data are available only with a substantial lag. For instance, when we developed this final rule the most recent professional liability data available from the state insurance commissioners were for 2000. Hence, the data currently incorporated into the MEI are much more timely.

Comment: Several commenters requested that we make an ad hoc adjustment to the MEI to account for recent increases in medical liability insurance.

Response: We disagree with the commenters that an ad hoc adjustment should be made to the MEI to account for recent increases in professional liability insurance. As detailed above, the current methodology reflects recent data collected directly from commercial insurance carriers and specifically reflects the conditions facing physicians. Thus, the MEI adequately accounts for the recent increases in professional liability insurance prices, much the same way it reflects the price changes associated with other inputs, such as office expenses, wages or benefits. Thus, we believe the MEI appropriately reflects the price changes as measured by reliable and relevant data sources, and should not be adjusted through an ad hoc mechanism.

Comment: Several commenters suggested that physicians' earnings more closely follow the wage changes faced by professional and technical occupations. The commenters suggested that we use the employment cost index (ECI) for professional and technical workers as the physicians' wage proxy in the MEI.

Response: As we stated in the November 2, 1998 final rule (63 FR 58848), we believe that the current price proxy for physicians' earnings, average hourly earnings (AHE) in the non-farm business economy, is the most appropriate proxy to use in the MEI. The AHE for the non-farm business economy reflects the impacts of supply, demand and economy-wide productivity for the average worker in the economy. Using the AHE as the proxy for physician earnings captures the parity in the rate of change in wages for the average worker and for physicians. In addition, use of this proxy is consistent with the original legislative intent that the change in the physicians' earnings portion of the MEI parallel the change in general earnings for the economy.

The suggestion to use the ECI for professional and technical workers has a major shortcoming in that, in many instances, occupations, such as engineers, computer scientists, nurses, etc., have unique characteristics that are not reflective of the overall economy or the physician market. Specifically, wage changes for these types of occupations can be influenced by excess supply or demand for these types of workers. We do not believe it would be appropriate to proxy the physician earnings portion of the MEI with a wage proxy that reflects these unique characteristics.

C. The Update Adjustment Factor

Section 1848(d) of the Act provides that the physician fee schedule update is equal to the product of the MEI and an ''update adjustment factor.'' The update adjustment factor is applied to make actual and target expenditures (referred to in the law as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the SGR. The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

Since the inception of the physician fee schedule in 1992, physician payment rates have been updated using two different systems. From 1992 to 1998, physician fee schedule rates were updated using the Medicare Volume Performance Standard (MVPS). From 1999 to the present, physician fee schedule rates have been updated using the sustainable growth rate (SGR). While there are significant and important differences between the MVPS and SGR, both use the same general concept that expenditures for physicians' services should grow by a limited percentage amount of allowed expenditures each year. If expenditures exceed the amount in a year, the physician fee schedule update is reduced. If expenditures are less than the amount of allowed expenditures in a year, the physician fee schedule update is increased.

We determined the annual percentage increase in expenditures using the formulas specified in the statute. One important feature of both the MVPS and the SGRs for fiscal years (FYs) 1998 and 1999 was that the percentage increase was based on estimates of the four factors specified in the law, made before the beginning of the year. Under the MVPS and the SGRs for FYs 1998 and 1999, the statute did not permit us to revise the estimates used to set the annual percentage increase. Beginning with the FY 2000 SGR, the statute specifically requires us to use actual, after the fact, data to revise the estimates used to set the SGR.

For some of the component factors of both the MVPS and the SGR, there have been differences between the estimates used to set the annual MVPS and SGR and the actual increase based on actual, after the fact, data. For instance, under both the MVPS and the SGR, we are required to account for increases in Medicare beneficiary fee-for-service enrollment. There have been differences between our estimates of the increase in fee-for-service enrollment and the actual, after the fact increase because it

is difficult to predict, before the beginning of the year, beneficiary enrollment in Medicare + Choice plans (or Medicare managed care plans as they were known under the MVPS). Under the MVPS, we generally estimated higher growth in beneficiary fee-for-service enrollment than actually occurred. For the FY 1998 and FY 1999 SGRs, we estimated lower growth in beneficiary fee-for-service enrollment than actually occurred. (For subsequent years, the statute has required us to revise our estimates.)

Under the SGR, the statute also requires us to account for the increase in real per capita gross domestic product (GDP) to determine the annual percentage increase in expenditures for physicians' services. In both FY 1998 and FY 1999, we estimated lower real per capita GDP growth than actually occurred. Because the statute did not permit us to revise estimates for these years, the SGRs for FYs 1998 and 1999 are lower than if we were authorized to revise estimates as required under current law for the FY 2000 SGR and all subsequent SGRs.

Because the physician fee schedule CF has been affected by a comparison of the actual increase in expenditures to the level of allowed expenditures calculated using the MVPS and the SGRs for FYs 1998–1999, revision of our estimates would have resulted in different CFs than those we actually determined. Revision of the estimates used to set the MVPS would have made the physician fee schedule CFs established under the MVPS lower than those we have actually determined. As a result, higher expenditures in 1997 were higher than if we had revised estimates with actual after the fact data. The actual amount of expenditures in 1997 forms the basis for the calculation of allowed expenditures under the SGR.

In contrast, revision of the estimates used to set the SGRs for FYs 1998 and 1999 would have resulted in higher physician fee schedule CFs for CY 2000 and all subsequent years than those we have actually determined. If the statute authorized revisions of the estimates used to establish both the MVPS and the SGRs for FYs 1998 and 1999, the physician fee schedule CF would be higher than it is currently.

We have analyzed the effect that revision of the estimates used to set the MVPS from FY 1990 through 1996 and the SGRs for FYs 1998 and 1999 would have on the physician fee schedule update for CY 2003 and subsequent years. The Department believes that a positive update could result if the statute authorized revisions of the estimates used to establish both the SGR for FYs 1998 and 1999 and MVPS for 1990 to 1996.

As noted above, however, current law does not permit the Department to adopt the positive update for 2003. In the event that Congress enacts legislation permitting the Department to make such an adjustment, the Department wishes to make the adjustment as promptly as possible. We therefore are soliciting public comments regarding the proper adjustments in the event that Congress authorizes the Department to make such an adjustment.

1. Calculation Under Current Law

Under section 1848(d)(4)(A) of the Act, the physician fee schedule update for a year is equal to the product of—(1) 1 plus the Secretary's estimate of the percentage increase in the MEI for the year, divided by 100 and (2) 1 plus the Secretary's estimate of the update adjustment factor for the year. Under section 1848(d)(4)(B) of the Act, the update adjustment factor for a year beginning with 2001 is equal to the sum of the following—

• Prior Year Adjustment Component. An amount determined by—

—Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for such services for that year;

—Dividing that difference by the amount of the actual expenditures for such services for that year; and

—Multiplying that quotient by 0.75.

• Cumulative Adjustment Component. An amount determined by—

—Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for such services during that period;

—Dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable growth rate for the year for which the update adjustment factor is to be determined; and

—Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming calendar year (2003 in this case), the current calendar year (2002) and the preceding calendar year (2001) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures are initially estimated and subsequently revised twice. The second revision occurs after the calendar year has ended (that is, we are making the final revision to 2001 allowed expenditures in this final rule). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 11 shows annual and cumulative allowed expenditures for physicians' services from April 1, 1996 through the end of the current calendar year, including the transition period to a calendar year system that occurred in 1999.

TABLE 11

Period	Annual allowed expenditures (Dollars)	Cumulative allowed expenditures (Dollars)	FY or CY SGR
4/1/96–3/31/97	48.9 billion	48.9 billion	N/A
4/1/97–3/31/98	49.6 billion	98.5 billion	FY 1998=1.5%
4/1/98–3/31/99	49.4 billion	147.9 billion	FY 1999=−0.3%
1/1/99–3/31/99	12.5 billion	Included in 147.9 above	FY 1999=−0.3%
4/1/99–12/31/99	39.6 billion	Included in 187.6 below	FY 2000=6.9%
1/1/99–12/31/99	52.1 billion	187.6 billion	FY 1999/FY 2000 (see note)
1/1/00–12/31/00	55.9 billion	243.5 billion	CY 2000=7.3%
1/1/01–12/31/01	58.4 billion	301.9 billion	CY 2001=4.5%
1/1/02–12/31/02	63.5 billion	365.4 billion	CY 2002=8.8%
1/1/03–12/31/03	68.3 billion	433.8 billion	CY 2003=7.6%

***Note:** Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR and allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR. Allowed expenditures in the first year (April 1, 1996–March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site under the Medicare Actuary's publications at the following address: *http://www.cms.hhs.gov/statistics/actuary/.* We expect to update the web site with the most current information later this month.

Consistent with section 1848(d)(4)(E) of the Act, table 12 includes our final revision of allowed expenditures for 2001, a recalculation of allowed expenditures for 2002, and our initial estimate of allowed expenditures for 2003. To determine the update adjustment factor for 2003, the statute requires that we use cumulative allowed expenditures from April 1, 1996 through December 31, 2002, actual expenditures through December 31, 2002, and the SGR for 2003, as well as annual allowed and actual expenditures for 2002. We are using estimates of allowed expenditures for 2002 and 2003 that will subsequently be revised consistent with section 1848(d)(4)(E) of the Act. Because we have incomplete expenditure data for 2002, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the update adjustment factor for future years.

We are using figures from table 12 in the statutory formula illustrated below:

$$UAF = \frac{Target_{02} - Actual_{02}}{Actual_{02}} \times .75 + \frac{Target_{4/96-12/02} - Actual_{4/96-12/02}}{Actual_{02} \times SGR_{03}} \times .33$$

UAF = Update Adjustment Factor.
$Target_{02}$ = Allowed Expenditures for 2002 or $63.5 billion.
$Actual_{02}$ = Estimated Actual Expenditures for 2002 = $69.1 billion.
$Target_{4/96-12/02}$ = Allowed Expenditures from 4/1/1996–12/31/2002 = $365.4 billion.
$Actual_{4/96-12/02}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2002 = $381.9 billion.
SGR_{03} = 7.6 percent (1.076).

$$\frac{\$63.5 - \$69.1}{\$69.1} \times .75 + \frac{\$365.4 - \$381.9}{\$69.1 \times 1.076} \times .33 = -.134$$

Section 1848(d)(4)(D) of the Act indicates that the update adjustment factor determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.07 or greater than 0.03. Because the calculated update adjustment factor of −0.134 is less than the statutory limit of −0.07, the update adjustment factor for 2003 will be −0.07.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the update adjustment factor determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the update adjustment factor equal to 0.930.

VII. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid for by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule, we are making our preliminary estimate of the 2003 SGR, a revision to the 2002 SGR, and our final revision to the 2001 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that the term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee. We published a definition of physicians' services for use in the SGR in the **Federal Register** (66 FR 55316) on November 1, 2001. We defined ''physicians' services'' to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs through December 31, 2002, we have specified that ''physicians' services'' include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers:

- Physicians' services.

• Services and supplies furnished incident to physicians' services.
• Outpatient physical therapy services and outpatient occupational therapy services.
• Antigens prepared by or under the direct supervision of a physician.
• Services of physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists.
• Screening tests for prostate cancer, colorectal cancer, and glaucoma.
• Screening mammography, screening pap smears, and screening pelvic exams.
• Diabetes outpatient self-management training services.
• Medical nutrition therapy services.
• Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.
• X-ray, radium, and radioactive isotope therapy.
• Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
• Bone mass measurements.

In the June 2002 proposed rule (67 FR 43861), we announced a change to our methodology for determining the ''weighted average percentage increase in fees for all physicians' services'' for the 2001 and subsequent year SGRs. We use a weighted average of the price indices that are used to increase payment for services included in the SGR to determine the percentage increase in fees for physicians' services. Physicians' services are updated using the MEI. Clinical diagnostic laboratory services are updated using the CPI. Drugs furnished ''incident to'' a physician's service under section 1861(s)(2)(A) of the Act, are also included in the calculation of the SGR. Under section 1842(o) of the Act, payments for drugs are based on 95 percent of average wholesale prices. We are currently using the MEI as a proxy for growth in drug prices. In the proposed rule, we indicated that, rather than using the MEI as proxy for growth in drug prices, we would use growth in actual drug prices to determine the weighted average percentage increase in fees for all physicians' services. In response, we received many comments suggesting that ''incident to'' drugs should not be included in the definition of physicians' services.

Comment: Comments indicated that the administration of a drug is a physician's service that, by statute, must be included in the definition of physicians' services. The drug itself, however, argued the comments, is not a physician service and should not be included in the SGR. A number of comments indicated that rising Medicare expenditures for drugs are due in large part to the introduction of costly new cancer drugs and not to the failure of physicians to control their use. Many of these comments stated that the increase in drug spending is due to government policies that encourage the rapid development of new drugs, as well as government efforts to urge Americans to be tested and seek early treatment for cancer and other diseases. Some comments indicated that physicians should not be forced to pay for the rising cost of drugs covered by Medicare through reduced fees. Other comments stated that including drugs in the SGR has not led to controls on drug spending and, as a result, removing them would not lead to increased spending. Other comments indicated that the SGR has not been increased to reflect the growing cost of drugs. These comments indicated that the SGR should either account for the growing cost of drugs or exclude them completely. One comment indicated that the SGR should account for the cost of new drugs approved by the FDA and covered by Medicare during the prior year and the cost of covered drugs that have the same biologic effect as non-covered drugs. Several comments indicated that the Secretary does not have the legal authority to include ''incident to'' drugs in the SGR because the section 1848(f) of the Act refers to physicians' services and not ''medical and other health services.'' Others provided copies of a detailed legal opinion arguing that drugs may be included in the SGR under section 1848(f) of the Act but cannot be included in the definition of physicians' services for purposes of determining the update adjustment factor under section 1848(d) of the Act.

Response: The statute provides the Secretary with clear authority to specify the services that are included in the SGR. Section 1848(f)(4)(A) of the Act indicates ''the term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services) specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office''. We disagree with the comments suggesting that the Secretary does not have the authority to include drugs in the definition of physicians' services for purposes of determining allowed expenditures, actual expenditures and the SGR. In reviewing section 1861(s) of the Act, we decided to include items and services in the SGR that are commonly furnished by physicians or in physicians' offices. Since ''incident to'' drugs covered under section 1861(s) of the Act are commonly furnished in physicians' offices, we are including these items in the SGR.

C. Provisions Related to the Sustainable Growth Rate

Section 211(b)(1) of the BBRA amended section 1848(f)(1) of the Act to require that three SGR estimates be published in the **Federal Register** not later than November 1 of every year. In this final rule, we are publishing our preliminary estimate of the SGR for 2003, a revised estimate of the SGR for 2002, and our final determination of the SGR for 2001. Consistent with section 1848(f)(3)(C) of the Act, we are using the best data available to us as of September 1, 2002 for all of the figures.

D. Preliminary Estimate of the Sustainable Growth Rate for 2003

Our preliminary estimate of the 2003 SGR is 7.6 percent. We first estimated the 2003 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and on our website. Table 12 shows our March estimates and our current estimates of the factors included in the SGR:

TABLE 12

Statutory factors	March estimate	Current estimate
Fees	1.7% (1.017)	2.9% (1.029)
Enrollment	1.3% (1.013)	1.2% (1.012)
Real per capita GDP	2.9% (1.029)	3.3% (1.033)
Law and regulation	0.0% (1.000)	0.0% (1.000)
Total	6.0% (1.060)	7.6% (1.076)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.029 × 1.012 × 1.033 × 1.000 = 1.076.) A more detailed explanation of each figure is provided below in section H.1.

E. Revised Sustainable Growth Rate for 2002

Our current estimate of the 2002 SGR is 8.8 percent. Table 13 shows our preliminary estimate of the 2002 SGR that was published in the **Federal Register** on November 1, 2001 (66 FR 55317) and our current estimate:

TABLE 13

Statutory factors	11/1/01 estimate	Current estimate
Fees	2.3 (1.023)	2.5% (1.025)
Enrollment	0.7 (1.007)	2.8% (1.028)
Real per capita GDP	1.7 (1.017)	2.3% (1.023)
Law and regulation	0.8 (1.008)	0.9% (1.009)
Total	5.6 (1.056)	8.8% (1.088)

A more detailed explanation of each figure is provided below in section H.2.

F. Final Sustainable Growth Rate for 2001

The SGR for 2001 is 4.5 percent. Table 14 shows our preliminary estimate of the SGR published in the **Federal Register** on November 1, 2000 (65 FR 65433), our revised estimate published in the **Federal Register** on November 1, 2001 (66 FR 55317) and the final figures determined using the latest available data:

TABLE 14

Statutory factors	11/1/00 estimate	11/1/01 estimate	Current estimate
Fees	1.9 (1.019)	1.9 (1.019)	2.1% (1.021)
Enrollment	0.9 (1.009)	3.0 (1.030)	3.0% (1.030)
Real per capita GDP	2.7 (1.027)	0.7 (1.007)	−0.7% (0.993)
Law and regulation	0.0 (1.000)	0.4 (1.004)	0.1% (1.001)
Total	5.6 (1.056)	6.1 (1.061)	4.5% (1.045)

A more detailed explanation of each figure is provided below in section H.2.

G. Calculation of 2003, 2002, and 2001 Sustainable Growth Rates

1. Detail on the 2003 SGR

A more detailed discussion of our preliminary estimates of the four elements of the 2003 SGR follows. We note that all of the figures used to determine the 2003 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and incorporated into subsequent physician fee schedule updates.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2003

This factor was calculated as a weighted average of the 2002 fee increases for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the physician fee schedule account for approximately 83.5 percent of total allowed charges included in the SGR and are updated using the MEI. The MEI for 2003 is 3.0 percent. Diagnostic laboratory tests represent approximately 8.0 percent of Medicare allowed charges included in the SGR and the costs of these tests are typically updated by the CPI–U. The CPI–U for 2003 that will be used to update clinical diagnostic laboratory tests is 1.1 percent. Drugs represent 8.5 percent of Medicare allowed charges included in the SGR. Medicare pays for drugs based on 95 percent of AWP under section 1842(o) of the Act. We calculated the weighted average fee increase for drugs to be included in the SGR, we estimate a weighted average fee increase for drugs of 3.3 percent in 2002. Table 15 shows the weighted average of the MEI, laboratory and drug price increases for 2003:

TABLE 15

	Weight	Update
Physician	0.835	3.0
Laboratory	0.080	1.1
Drugs	0.085	3.3
Weighted Average	1.000	2.9

After taking into account the elements described in table 16, we estimate that the weighted-average increase in fees for physicians' services in 2002 under the SGR (before applying any legislative adjustments) will be 2.9 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2002 to 2003

This factor is our estimate of the percent change in the average number of

fee-for-service enrollees from 2002 to 2003. Services provided to Medicare+Choice (M+C) plan enrollees are outside the scope of the SGR and are excluded from this estimate. Our actuaries estimate that the average number of Medicare Part B fee-for-service enrollees will increase by 1.2 percent from 2002 to 2003. Table 16 illustrates how this figure was determined:

TABLE 16

	2002	2003
Overall	37.986 million	38.321 million
Medicare+Choice	5.070 million	5.012 million
Net	32.916 million	33.309 million
Percent Increase	.....	1.2 percent

An important factor affecting fee-for-service enrollment is beneficiary enrollment in Medicare+Choice plans. Because it is difficult to estimate the size of the Medicare+Choice enrollee population before the start of a calendar year, at this time, we do not know how actual enrollment in Medicare+Choice plans will compare to current estimates. For this reason, there may be substantial changes to this estimate as actual Medicare fee-for-service enrollment for 2003 becomes known.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2003

We estimate that the growth in real per capita GDP from 2002 to 2003 will be 3.3 percent. Our past experience indicates that there have also been large changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is likely that this figure will change as actual information on economic performance becomes available to us in 2003.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2003 Compared With CY 2002

As indicated below, section 101–104 of the BIPA added Medicare coverage for a variety of new services. We estimate no additional costs for these services in 2003 relative to 2002. We will continue to monitor utilization of all of the new benefits provided in BIPA and modify our estimates (up or down) and the SGRs accordingly.

Comment: We received many comments indicating that we should adjust the SGR to account for the addition of the psychiatric diagnostic interview to the list of covered telehealth services.

Response: We agree that the addition of the psychiatric diagnostic interview is a change in regulation that should be accounted for in the SGR. However, since there is such low utilization of the telehealth benefit, we believe the addition of the psychiatric diagnostic interview to the list of covered telehealth services will have no impact on the SGR.

Comment: Several comments noted that section 112 of BIPA changed Medicare's drug payment policy. Prior to the enactment of the BIPA, section 1861(s)(2) of the Act allowed Medicare to pay for ''drugs and biologicals, which cannot, as determined in accordance with regulations, be self-administered.'' The BIPA amended the Act to allow Medicare to pay for drugs which ''are not usually administered by the patient.'' The commenters believe that this new drug payment policy will result in an increase in expenditures that should be accounted for in the SGR.

Response: The amendments to Medicare's drug payment policy contained in section 112 of the BIPA constitute a change in law or regulation that is taken into account in determining the SGR. We estimate a 2002 cost for this policy change that will be accounted for in the 2002 SGR described below. At this time, we are not estimating additional Medicare costs in 2003 relative to 2002 for drugs not usually self-administered by patients.

Comment: We received many public comments that argued for adjusting the SGR for changes in expenditures resulting from NCDs. According to these comments, any changes in national Medicare coverage policy that are adopted by us pursuant to a formal or informal rulemaking, such as a Program Memorandum or a national Medicare coverage determination, constitute a regulatory change for purposes of computing factor 4 of the SGR. The comments indicate that our authority to make any regulatory change is derived from law—whether it is a law specifically authorizing Medicare coverage of a new service or a law that provides general rulemaking authority. According to these comments, any new coverage initiative is a direct implementation, by regulation, of a law that should be taken into account in determining the SGR. One commenter indicated that we effectively compare actual expenditure data that include additional utilization resulting from NCDs with a spending target that does not include this additional utilization, making it more likely that the target will be exceeded.

Response: We carefully considered this comment. If the Congress adds a new statutory benefit (for example, medical nutrition therapy), we are required by law to increase the target. Medicare does not have authority to pay for a service lacking a defined statutory benefit listed in section 1861(s) of the Act (for example, prior to January 1, 2002, there was no authority for Medicare to pay for medical nutrition therapy). However, we do have the authority to establish national coverage policies for items and services that are included in a benefit category listed in section 1861(s) of the Act. Further, we contract with Medicare carriers who may establish local coverage policies for items and services that have a statutory benefit category.

The statute requires that real GDP per capita be used in setting the SGR target. We believe that use of real GDP per capita was intended as a proxy for a number of factors that may increase the volume and intensity of physicians' services (other than beneficiary enrollment and statutory changes that increase expenditures, which are separately accounted for by the statute), such as those associated with coverage of new items or services and other miscellaneous factors that cannot be specifically identified, such as any spending associated with NCDs.

The large majority of Medicare spending is for services that are covered at local carrier discretion. While we may establish national coverage (or non-coverage) for a new item or service with a defined statutory benefit category, this NCD does not necessarily increase Medicare spending to the extent that the service has or would have been covered at local carrier discretion in the absence

of a NCD. For instance, there was widespread publicity in 2000 about ocular photodynamic therapy (OPT), a new treatment for macular degeneration, a common cause of blindness in the elderly. Prior to our NCD, Medicare carriers had the authority to cover OPT at local carrier discretion as a physician's service under section 1861(s)(1) of the Act. Given the widespread publicity about the effectiveness of this new treatment, it is likely that, in the absence of a NCD, OPT would have been covered at local carrier discretion. That is, application of existing Medicare law and regulations would have allowed Medicare coverage for OPT at local carrier discretion. Because it seems likely that Medicare would covered this procedure in any event, it is unclear whether there are any additional costs associated with the NCD. Indeed the NCD limited the coverage of OPT to a defined subpopulation of Medicare beneficiaries. The local contractor determinations may not have done so, and therefore, the NCD may actually have resulted in a net savings to Medicare. Moreover, we did not change the law or regulations by making a national coverage decision for OPT. Rather, we applied existing law and regulations to a new service to make a national statement about coverage where one did not previously exist.

We may also issue a NCD to clarify Medicare coverage for existing items or services. Such a decision may establish national policy that replaces differing local practices. In such a case, there may not have been consistency among Medicare carriers as to whether an item or service qualified for coverage based on existing law or regulation. Thus, our NCD would not change law or regulation, but replaces differing local practices with a national determination that, based on existing law and regulations, clarifies Medicare coverage for an item or service. Spending may increase or decrease depending upon the degree to which the particular item or service is currently being covered by Medicare carriers and whether the decision is to establish coverage or non-coverage of the item or service.

For the reasons previously discussed, it would be very difficult to estimate any costs or savings associated with specific coverage decisions. Further, we believe any adjustment to the target would likely be of such a small magnitude that it would have little effect on future projected updates.

1. Detail on the 2002 SGR

A more detailed discussion of our revised estimates of the four elements of the 2002 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2002

This factor was calculated as a weighted average of the 2002 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the physician fee schedule account for approximately 84.5 percent of total allowed charges included in the SGR, and are updated using the MEI. The MEI for 2002 is 2.6 percent. Diagnostic laboratory tests represent approximately 7.5, and the costs of these tests are typically updated by the CPI–U. However, the BBA required a 0.0 percent update in 2002 for laboratory services. Drugs represent 8.0 percent of Medicare allowed charges included in the SGR. Pursuant to section 1842(o) of the Act, Medicare pays for drugs based on 95 percent of AWP. Using wholesale pricing information and Medicare utilization for drugs included in the SGR, we estimate a weighted average fee increase for drugs of 3.3 percent in 2002. Table 17 shows the weighted average of the MEI, laboratory and drug price increases for 2002:

TABLE 17

	Weight	Update
Physician	0.845	2.6
Laboratory	0.075	0.0
Drugs	0.080	3.3
Weighted Average	1.000	2.5

After taking into account the elements described in table 18, we estimate that the weighted-average increase in fees for physicians' services in 2002 under the SGR (before applying any legislative adjustments) will be 2.5 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees from 2001 to 2002

Our actuaries estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) increased by 2.8 percent in 2002. Table 18 illustrates how we determined this figure:

TABLE 18

	2001	2002
Overall	37.633 million	37.986 million
Medicare+Choice	5.608 million	5.070 million
Net	32.025 million	32.916 million
Percent Increase	.....	2.8 percent

Our actuaries' estimate of the 2.8 percent change in the average number of fee-for-service enrollees, net of Medicare+Choice enrollment for 2002, compared to 2001 is different from our preliminary estimate (0.7 percent for 2002 from the November 1, 2001 final rule (66 FR 55318)) because the historical base from which our actuarial estimate is made has changed. We now have complete information on Medicare fee-for-service enrollment for 2001 that is different than the figure we used one year ago. Further, we now have information on actual fee-for-service

enrollment for the first 8 months of 2002. We would caution that our estimate of fee-for-service enrollment for 2002 may change again once we have complete information for the entire year.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2002

We estimate that the growth in real per capita GDP will be 2.3 percent in 2002. Our past experience indicates that there have also been large differences between our preliminary estimates of real per capita GDP growth and the actual change in this factor. Thus, it is likely that this figure will change further as actual information on economic performance becomes available to us in 2003.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2002 Compared With 2001

As indicated earlier, sections 101 through 104 of the BIPA added Medicare coverage for a variety of new services that will affect the 2002 SGR. We included an adjustment in the 2002 SGR based on previous estimates of the costs of these new benefits, but are reducing our estimate of the costs of the new telehealth and medical nutrition therapy benefits based on lower utilization of these services than we had originally anticipated. This change will have little effect on this factor and we are not changing our estimate of the costs of any of the other provisions described earlier. In addition, as explained above, section 112 of BIPA made changes that will result in additional Medicare coverage for certain drugs. Prior to the enactment of the BIPA, Medicare only paid for drugs that cannot be self-administered by the patient. BIPA allows Medicare to pay for drugs that can be but are not usually self-administered. Accordingly, we are accounting for the increased Medicare drug expenditures that will result from implementation of section 112 of the BIPA. After taking these provisions into account, the percentage change in expenditures for physicians' services resulting from changes in law or regulations is estimated to be 0.9 percent for 2002.

3. Detail on the 2001 SGR

A more detailed discussion of our current estimates of the four elements of the 2001 SGR follows. Pursuant to section 1848(f)(3)(C) of the Act, we will be making no further revisions to these figures.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2001

We are using a weighted average of the fee increases that apply to the different services included in the SGR for 2001. Services that are updated by the MEI represent 85.7 percent of allowed charges included in the SGR. The 2001 MEI was 2.1 percent. Pursuant to the BBA, laboratory services were updated by 0.0 percent in 2001 and represent 7.0 percent of allowed charges included in the SGR. The weighted average percentage increase in average wholesale prices for drugs included in the SGR in 2001 was 3.4 percent. Drugs represent 7.3 percent of allowed charges included in the SGR. Using these figures, the weighted average percentage increase in fees for physicians' services is illustrated in table 19:

TABLE 19

	Weight	Update
Physician	0.857	2.1
Laboratory	0.070	0.0
Drugs	0.073	3.4
Weighted Average	1.000	2.1

Factor 2—The Percentage Change in the Average Number of Fee-for-Service Part B Enrollees From 2000 to 2001

We estimate the increase in the average number of fee-for-service enrollees (excluding Medicare+Choice enrollees) from 2000 to 2001 was 3.0 percent. Table 20 illustrates the calculation of this factor:

TABLE 20

	2000	2001
Overall	37.330 million	37.633 million
Medicare+Choice	6.233 million	5.608 million
Net	31.098 million	32.205 million
Percent Increase	.....	3.0 percent

Our calculation of this factor is based on complete data from 2001.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2001

We estimate that the growth in real per capita GDP was −0.7 percent in 2001. This is a final figure based on complete data for 2001.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2001 Compared With CY 2000

As described above, the BIPA makes changes to the Act that affect Medicare expenditures for services included in the SGR. Some of these provisions had no effect on Medicare expenditures in 2001 because they did not go into effect until 2002. Other provisions became effective at some time during 2001. These provisions relate to coverage of new technology mammography, coverage changes for screening pap smears, screening pelvic exams, screening colonoscopy, expanded access to telehealth services, and Medicare payment for services provided in Indian Health Service hospitals and clinics. After taking these provisions into

account, the percentage change in expenditures for physicians' services resulting from changes in law or regulations is estimated to be 0.1 percent for 2001.

VIII. Anesthesia and Physician Fee Schedule Conversion Factors

The 2003 physician fee schedule CF will be $34.5920. The 2003 national average anesthesia conversion factor is $16.0353.

The specific calculations to determine the physician fee schedule and anesthesia CFs for 2003 are explained below.

Detail on Calculation of the 2003 Physician Fee Schedule Conversion Factor

- Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the physician fee schedule CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act. In addition, section 1848(c)(2)(B)(ii)(II) of the Act requires that changes to RVUs cannot cause the amount of expenditures to increase or decrease by more than $20 million from the amount of expenditures that would have been made if such adjustments had not been made. We implement this requirement through a uniform budget neutrality adjustment to the CF. There is one change that will require us to make an adjustment to the conversion factor to comply with the budget neutrality requirement in section 1848(c)(2)(B)(ii)(II) of the Act. We are making a 0.04 percent reduction (0.9996) in the CF to account for the increase in anesthesia work resulting from the 5-year review.

We are illustrating the calculation for the 2003 physician fee schedule CF in table 21:

TABLE 21

2002 Conversion Factor	$36.1992
2003 Update	0.9560
Budget-Neutrality Adjustment: Increase in Anesthesia Work	0.9996
2003 Conversion Factor	34.5920

- Anesthesia Fee Schedule Conversion Factor

Because anesthesia services do not have RVUs like other physician fee schedule services, we are accounting for the increase in anesthesia work through an adjustment to the anesthesia fee schedule conversion factor. As indicated earlier, we are increasing the physician work component of the anesthesia conversion factor by 2.10 percent to reflect a 9.13 percent increase in payment applied to 23 percent of anesthesia allowed charges. The 2002 anesthesia CF is $16.60. The physician work portion of the anesthesia conversion factor is 78 percent. We applied a 1.6 percent (1.016) increase to this part of the anesthesia conversion factor. Similarly, we also simulated the effect of practice expense refinements on the practice expense portion of the anesthesia conversion factor. The refinements reduced this portion of the anesthesia conversion factor by 4.04 percent (0.9596). In addition, we are also applying the physician fee schedule update and the budget neutrality adjustment for the increase in anesthesia work that that also apply to the physician fee schedule CF. To determine the anesthesia fee schedule CF for 2003, we used the following figures:

TABLE 22

2002 Anesthesia Conversion Factor	$16.6055
Adjustments for work and practice expense	1.0106
2003 Update	0.9560
Budget-Neutrality Adjustment: Increase in Anesthesia Work	0.9996
2003 Conversion Factor	16.0353

IX. Provisions of the Final Rule

This final rule adopts the provisions of the June 2002 proposed rule, except as noted elsewhere in the preamble. The following is a highlight of the changes made from the proposed rule.

For immunization administration, we are developing practice expense RVUs for influenza, pneumonia, and hepatitis B vaccine G codes. This will increase the payment for these codes and make Medicare's payment for vaccine administration more consistent with the rates paid for the CPT codes.

For anesthesia, we are revising the regulations text at § 414.46(g) to incorporate that the policy on multiple procedure codes as well as add-on codes.

For enrollment of PTs and OTs as therapists in private practice, we are revising our regulations text at § 410.59 and § 410.60 to reflect that carriers and fiscal intermediaries can enroll therapists as PTs or OTs in private practice when the therapist is employed by physician groups or groups that are not professional corporations.

We are adopting the process to add or delete telehealth services and adding the psychiatric diagnostic interview examination to the list of telehealth services. In addition, we are referencing the process to add or delete services at new § 410.78(f).

For the definition of a ZZZ global period, we are revising the definition to show that physician work is associated with intraservice time and, in some instances, the pre- and postservice time.

For the definition of a screening fecal-occult blood test, we are revising the definition at § 410.37(a)(2) to permit coverage of non-guaiac based tests.

For the critical access hospital emergency services requirement we are modifying § 485.618(d) to include RNs.

X. Waiver of Proposed Rulemaking for Definition of a Screening Fecal-Occult Blood Test and Critical Access Hospital Emergency Services Requirement

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on proposed rules. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

In our proposed rule, we did not propose to modify § 410.37. Still, we received a comment seeking to modify coverage for one particular type of colorectal cancer test, a fecal-occult blood test. As explained earlier in this preamble, we have agreed to modify this regulation in a manner that would permit broader Medicare coverage if that is determined to be appropriate. Consistent with this change, we are modifying § 410.37(a)(1)(v) to announce that we will consider approving new tests or procedures for use in the early detection of colorectal cancer through our process for making national coverage determinations.

The Congress has authorized the Secretary to cover additional tests or procedures that can be used for the early detection of colorectal cancer under the Colorectal Cancer Screening Test benefit in under part B in section 1861(pp)(1)(D) of the Act. The Secretary may determine that coverage of other tests or procedures are appropriate, in consultation with appropriate organizations. We are aware that new colorectal cancer screening tests are

being developed. To determine whether it is appropriate to expand coverage to provide Medicare payment for additional tests or procedures, it will be necessary to compare the new tests to tests that are already covered. We are modifying § 410.37(a)(1)(v) to permit determinations on whether to cover (or not cover) additional tests or procedures to be made through NCDs.

Expanding Medicare coverage of additional, effective, and appropriate screening tests would be in the public interest because the tests may discover patients with cancer at an earlier stage, increasing the chances that the patient will obtain proper medical treatment. An NCD, authorized by section 1869(a)(2) of the Act, can be used to develop a national policy regarding the scope of benefits. Moreover, the process for making an NCD will permit public participation, as well as the participation of appropriate groups, as the agency determines whether or not expanded coverage for additional tests or procedures is appropriate. This process offers advantages to the public because it could permit an expansion in the scope of the colorectal cancer screening benefit more rapidly than the notice and comment procedures of the Administrative Procedure Act would normally permit.

In addition, we did not propose to modify § 485.618(d). A delay in implementation of this provision would hinder the ability of small CAHs (with no greater than 10 beds) in some frontier areas or remote locations to provide the necessary critical access hospital emergency services. It was brought to our attention that, in recent months, a number of small CAHs in very remote frontier areas have been struggling to comply with the CAH standard in § 485.618(d) that requires CAHs to have either a doctor of medicine or osteopathy, a physician's assistant, or a nurse practitioner, with training or experience in emergency care to ensure emergency coverage 24-hours-a-day, seven-days-a-week. These CAHs have 10 or less beds. In order to provide additional flexibility for other CAHs of virtually the same size, we believe 10 beds is an appropriate size limit for facilities that may be in the same situation and require potential relief from the existing staffing requirements. These facilities, located in isolated frontier communities, have only one medical practitioner and see a low volume of patients. For these providers the requirement referenced above results in a significant personal hardship to the sole practitioner who must be on call 24-hours-a-day, 52-weeks-a-year. In addition, it is a financial hardship for the facility to find a replacement for the currently required emergency services personnel because frequently the replacement costs far exceed what is recovered through the services provided. We believe that by allowing States to include RNs in the current critical access hospital emergency services personnel requirement, so that RNs may be on call for small CAHs in frontier areas or remote locations, we will help ensure that frontier communities will have continued access to CAH services. In addition, if small CAHs in frontier areas or remote locations close their doors there would be no access to care in these communities.

Accordingly, we find good cause for waiving the prior notice-and-comment procedures as unnecessary and contrary to the public interest. In addition, we note that rules of agency procedure are exempt from the notice and comment requirements of 5 U.S.C. 553.

XI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-days notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 485.618 permits a CAH located in an area designated as a frontier area or remote location described in paragraph (d)(1)(i) to include in the personnel requirement in paragraph (d) a RN, if the State in which the small CAH is located submits a letter to us, signed by the Governor, following consultation with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a RN be included temporarily in the list of personnel that must be on call and available on site within 60 minutes.

Since we anticipate that we will receive approximately five requests for an inclusion of RNs on an annual basis, this collection requirement is not subject to the PRA as stipulated under 5 CFR 1320.3(c).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations & Regulatory Affairs, RDIG, Attn.: John Burke, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

XII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

XIII. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or

communities). We have simulated the effect of increases in payment for anesthesia work and the changes to practice expense RVUs described earlier. The net effect of the changes will not materially increase or decrease Medicare expenditures for physicians' services because the statute requires that these changes cannot increase or decrease expenditures more than $20 million. Since increases in payments resulting from the 5-year review anesthesia work and practice expense RVU changes cannot increase or decreases expenditures by more than $20 million, any increases or decreases in payment will result in a redistribution of payments among physician specialties. The proposed changes to the MEI would result in increases in Medicare expenditures for physicians' services of $150 million in fiscal year (FY) 2003, $340 million in FY 2004, and $550 million in FY 2005. Therefore, this rule is considered to be a major rule because it is economically significant, and, thus, we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a Regulatory Flexibility Analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds.

For purposes of the RFA, physicians, non-physician practitioners, and suppliers, are considered small businesses if they generate revenues of $8.5 million or less. Approximately 96 percent of physicians are considered to be small entities. There are about 700,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule. In addition, CAHs are considered small entities, either by nonprofit status or by having revenues of $6 to $29 million in any one year.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. We have determined that this proposed rule will have no consequential effect on State, local, or tribal governments.

We have examined this final rule in accordance with Executive Order 13132 and have determined that this regulation would not have any negative impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which together with the rest of this preamble, meets all assessment requirements. It explains the rationale for, and purposes of, the rule, details the costs and benefits of the rule, analyzes alternatives, and presents the measures we are using to minimize the burden on small entities. As indicated elsewhere, we are making changes to the Medicare Economic Index, refining resource-based practice based practice expense RVUs, and making a variety of other changes to our regulations, payments, or payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections in this rule. In large part, the provisions of this rule are changing only Medicare payment rates for physician fee schedule services. While this rule allows physical and occupational therapists that are employed by physicians to separately enroll in the Medicare program, it does not impose reporting, recordkeeping, and other compliance requirements. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this rule. The relevant sections of this contain a description of significant alternatives.

A. Resource-Based Practice Expense Relative Value Units

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are proposing several changes that would result in a change of expenditures that would exceed $20 million if we made no offsetting adjustments to either the CF or RVUs.

With respect to practice expense, our policy has been to meet the budget-neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodology. That is, we estimate the aggregate number of practice expense RVUs that would be paid under current policies and under the policies we will be using in 2003. We apply a uniform adjustment factor to make the aggregate number of proposed practice expense relative values equal the number estimated that would have been paid under current policy. Consistent with section 1848(c)(2)(B)(ii)(II) of the Act, we ensure that changes to practice expense RVUs do not increase or decrease payments more than $20 million. We are also applying a 0.49 percent (0.9951) reduction to the practice expense RVUs to account for an anticipated increase in the volume and intensity of services in response to payment reductions from refinement of practice expense RVUs.

Table 23 shows the specialty level impact of RVU changes on payment in 2003. As indicated in the June 2002 proposed rule (67 FR 43869), we are showing more specialty categories in our impact tables in this final rule than we have in the past. This change was well-received by the public, and we will continue to show impacts for the more detailed list of physician specialties, non-physician practitioners and medical suppliers. As indicated in the proposed rule, it is important to note that the payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here since physicians furnish services to both Medicare and non-Medicare patients and certain specialties may receive substantial Medicare revenues for services that are not paid under the physician fee schedule. For instance, independent laboratories receive more than 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedule. Table 23 shows only the payment impact on physician fee schedule services.

We modeled the impact of several changes that will affect payment for physician fee schedule services in CY 2003. The column labeled ''NPRM'' shows the impacts of our proposed rule policies and reflects the figures shown in the June 28, 2002 proposed rule (67 FR 43867). The remaining columns show additional impacts that will result from changes made in this final rule in response to comments. The column labeled practice expense refinements

shows the impact on payment resulting from changes to practice expense inputs that are described in section II.A. As indicated earlier, we are making refinements to over 1,100 procedure codes. These changes result in little or no impact for most specialties. Dermatology, nephrology, and audiology will experience an approximate reduction in payment of 3 percent as a result of these changes. Payment will decline by an estimated 2 percent for others (clinical social workers, independent diagnostic testing facilities) while reductions in payments will be more modest for a few other specialties (cardiac surgery, neurosurgery, clinical psychology, orthopedic surgery and physician assistants). Payment will increase by an estimated 4 percent for independent laboratories as a result of these changes and by 2 percent for plastic surgery. Other specialties will experience smaller increases in payments from the practice expense refinements (endocrinology, family practice, general practice, obstetrics, gynecology, pediatrics, physical medicine, rhematology, urology, chiropractor, and optometry).

The column labeled ''5-Year Review'' shows the impact revisions to payments for anesthesia services resulting from the 5-year review of physician work. As expected, the increase in anesthesia work results in a 1-percent increase in payment to anesthesiologists and a 2-percent increase to certified registered nurse anesthetists (CRNAs) that bill Medicare for anesthesia services. CRNAs bill Medicare almost exclusively for anesthesia services. Anesthesiologists bill Medicare for anesthesia services and other physician fee schedule services. The net increase in payment is slightly less for anesthesia services because it reflects the average increase in payment for anesthesia services and other physician fee schedule services that are not increasing as a result of the 5-year review

The column labeled ''All Other Changes'' reflects all changes that affect practice expense RVUs described in section II. A. These changes include: (1) As requested by the American Urology Association (AUA), removing several codes From the non-physician work pool; (2) incorporating supplemental data from the American Physical Therapy Association (APTA) and; (3) continuing to determine the global practice expense RVUs as the sum of the PC and TC practice expense RVUs for pathology services. While removing the codes requested by the AUA will increase payments to urologists, it will result in a somewhat smaller increase in payment than proposed for the services remaining in the non-physician work pool. As expected, incorporating supplemental survey data will increase payment to physical and occupational therapists. Payment reductions to pathology and independent laboratories resulting from determining the TC value as the difference between the global and PC will not occur in CY 2003 since we are not making this change for 1 year for pathology services paid using the physician fee schedule.

The column labeled ''Total'' shows the combined effect of all RVU changes on average Medicare payments for the specialties shown. The net effect of our final rule will continue to benefit several types of suppliers that provide services that are affected by the non-physician work pool methodology. Payments to Independent Diagnostic Testing Facilities will increase by approximately 4 percent. Portable x-ray suppliers will also receive an approximate increase of 4 percent in payments for services paid under the physician fee schedule. However, we note that only about 47 percent of Medicare revenues received by portable x-ray suppliers are attributable to physician fee schedule services. The other Medicare revenues received by portable x-ray suppliers are attributed to the transportation of x-ray equipment paid at rates determined by the Medicare carrier. Any change to the rates for carrier-priced services would be made at local carrier discretion. We recently asked our Medicare carriers to analyze payment for portable x-ray transportation since it has been a number of years since payment for this service has been reviewed.

TABLE 23.—IMPACT OF WORK AND PRACTICE EXPENSE CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY

Category	Medicare allowed charges ($ in billions)	NPRM (percent)	Practice expense refinements (percent)	5-year review (percent)	All other changes (percent)	Total (percent)
Physicians:						
ALLERGY/IMMUNOLOGY	0.14	2	0	0	0	1
ANESTHESIOLOGY	1.24	−1	0	1	0	1
CARDIAC SURGERY	0.28	0	−1	0	0	−1
CARDIOLOGY	4.75	1	0	0	−1	1
CLINICS	2.57	0	0	0	0	0
DERMATOLOGY	1.55	−2	−3	0	1	−4
EMERGENCY MEDICINE	1.17	0	0	0	0	0
ENDOCRINOLOGY	0.21	0	1	0	−1	0
FAMILY PRACTICE	3.43	0	1	0	0	0
GASTROENTEROLOGY	1.34	−1	0	0	0	−1
GENERAL PRACTICE	0.84	0	1	0	0	0
GENERAL SURGERY	1.98	−1	0	0	0	−1
GERIATRICS	0.08	0	0	0	0	0
HEMATOLOGY/ONCOLOGY	0.95	1	0	0	0	1
INFECTIOUS DISEASE	0.28	−1	0	0	0	−1
INTERNAL MEDICINE	6.77	0	0	0	0	0
INTERVENTIONAL RADIOLOGY	0.14	1	0	0	−2	−1
NEPHROLOGY	1.09	−1	−3	0	0	−4
NEUROLOGY	0.91	2	0	0	0	2
NEUROSURGERY	0.38	−1	−1	0	0	−1
OBSTETRICS/GYNECOLOGY	0.48	0	1	0	0	1
OPHTHALMOLOGY	3.86	−1	0	0	0	−1
ORTHOPEDIC SURGERY	2.40	0	−1	0	0	−2
OTOLARNGOLOGY	0.66	0	0	0	−1	−1

TABLE 23.—IMPACT OF WORK AND PRACTICE EXPENSE CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY PHYSICIAN, PRACTITIONER AND SUPPLIER SUBCATEGORY—Continued

Category	Medicare allowed charges ($ in billions)	NPRM (percent)	Practice expense refinements (percent)	5-year review (percent)	All other changes (percent)	Total (percent)
PATHOLOGY	0.69	−2	0	0	2	0
PEDIATRICS	0.05	0	1	0	0	1
PHYSICAL MEDICINE	0.49	1	1	0	0	2
PLASTIC SURGERY	0.25	−1	2	0	0	0
PSYCHIATRY	1.00	0	0	0	0	−1
PULMONARY DISEASE	1.12	0	0	0	0	0
RADIATION ONCOLOGY	0.81	3	0	0	−2	1
RADIOLOGY	3.47	2	0	0	−1	1
RHEUMATOLOGY	0.30	0	1	0	−1	0
THORACIC SURGERY	0.43	0	0	0	0	−1
UROLOGY	1.36	−1	1	0	2	2
VASCULAR SURGERY	0.37	2	0	0	0	1
Other Practitioners:						
AUDIOLOGIST	0.02	8	−3	0	−2	2
CHIROPRACTOR	0.50	−1	1	0	0	−1
CLINICAL PSYCHOLOGIST	0.40	1	−1	0	0	0
CLINICAL SOCIAL WORKER	0.23	0	−2	0	0	−1
NURSE ANESTHETIST	0.38	−1	0	2	0	1
NURSE PRACTITIONER	0.30	0	0	0	0	0
OPTOMETRY	0.54	−2	1	0	−1	−1
PHYSICAL/OCCUPATIONAL THERAPY	0.61	0	0	0	3	2
PHYSICIANS ASSISTANT	0.23	0	−1	0	0	−1
PODIATRY	1.17	−1	0	0	0	0
Suppliers:						
DIAGNOSTIC TESTING FACILITY	0.51	9	−2	0	−4	3
INDEPENDENT LABORATORY	0.43	−8	4	0	8	3
PORTABLE X-RAY SUPPLIER	0.07	8	0	0	−3	4
ALL OTHER	0.29	0	−1	0	0	−1
ALL PHYSICIAN FEE SCHEDULE	53.53	0	0	0	0	0

Table 24 shows the combined impact of changes in payment due to RVUs and the physician fee schedule update. As described in section V, section 1848(d)(4) of the Act requires the physician fee schedule update to be −4.4 percent. We do not have the authority to change the physician fee schedule update formula specified in the statute. Table 24 shows the estimated change in average payments by specialty based on the provisions of this final rule and the physician fee schedule update.

TABLE 24.—ESTIMATED IMPACT OF ALL CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY SPECIALTY

Category	Medicare allowed charges ($ in billions)	5 Year review/ RVU changes percent	Physician fee schedule update percent	Total percent
Physicians:				
ALLERGY/IMMUNOLOGY	0.14	1	−4.4	−3
ANESTHESIOLOGY	1.24	1	−4.4	−3
CARDIAC SURGERY	0.28	−1	−4.4	−6
CARDIOLOGY	4.75	1	−4.4	−4
CLINICS	2.57	0	−4.4	−5
DERMATOLOGY	1.55	−4	−4.4	−8
EMERGENCY MEDICINE	1.17	0	−4.4	−5
ENDOCRINOLOGY	0.21	0	−4.4	−5
FAMILY PRACTICE	3.43	0	−4.4	−5
GASTROENTEROLOGY	1.34	−1	−4.4	−5
GENERAL PRACTICE	0.84	0	−4.4	−4
GENERAL SURGERY	1.98	−1	−4.4	−5
GERIATRICS	0.08	0	−4.4	−5
HEMATOLOGY/ONCOLOGY	0.95	1	−4.4	−3
INFECTIOUS DISEASE	0.28	−1	−4.4	−5
INTERNAL MEDICINE	6.77	0	−4.4	−5
INTERVENTIONAL RADIOLOGY	0.14	−1	−4.4	−5
NEPHROLOGY	1.09	−4	−4.4	−8
NEUROLOGY	0.91	2	−4.4	−2
NEUROSURGERY	0.38	−1	−4.4	−6

TABLE 24.—ESTIMATED IMPACT OF ALL CHANGES ON TOTAL MEDICARE ALLOWED CHARGES BY SPECIALTY—Continued

Category	Medicare allowed charges ($ in billions)	5 Year review/ RVU changes percent	Physician fee schedule update percent	Total percent
OBSTETRICS/GYNECOLOGY	0.48	1	−4.4	−3
OPHTHALMOLOGY	3.86	−1	−4.4	−5
ORTHOPEDIC SURGERY	2.40	−2	−4.4	−7
OTOLARNGOLOGY	0.66	−1	−4.4	−5
PATHOLOGY	0.69	0	−4.4	−5
PEDIATRICS	0.05	1	−4.4	−4
PHYSICAL MEDICINE	0.49	2	−4.4	−3
PLASTIC SURGERY	0.25	0	−4.4	−4
PSYCHIATRY	1.00	−1	−4.4	−5
PULMONARY DISEASE	1.12	0	−4.4	−4
RADIATION ONCOLOGY	0.81	1	−4.4	−3
RADIOLOGY	3.47	1	−4.4	−4
RHEUMATOLOGY	0.30	0	−4.4	−4
THORACIC SURGERY	0.43	−1	−4.4	−5
UROLOGY	1.36	2	−4.4	−3
VASCULAR SURGERY	0.37	1	−4.4	−3
Other Practitioners:				
AUDIOLOGIST	0.02	2	−4.4	−2
CHIROPRACTOR	0.50	−1	−4.4	−5
CLINICAL PSYCHOLOGIST	0.40	0	−4.4	−4
CLINICAL SOCIAL WORKER	0.23	−1	−4.4	−5
NURSE ANESTHETIST	0.38	1	−4.4	−4
NURSE PRACTITIONER	0.30	0	−4.4	−5
OPTOMETRY	0.54	−1	−4.4	−5
PHYSICAL/OCCUPATIONAL THERAPY	0.61	2	−4.4	−3
PHYSICIANS ASSISTANT	0.23	−1	−4.4	−6
PODIATRY	1.17	0	−4.4	−5
Suppliers:				
DIAGNOSTIC TESTING FACILITY	0.51	3	−4.4	−1
INDEPENDENT LABORATORY	0.43	3	−4.4	−1
PORTABLE X−RAY SUPPLIER	0.07	4	−4.4	0
ALL OTHER	0.29	−1	−4.4	−6
ALL PHYSICIAN FEE SCHEDULE	53.53	0	−4.4	−5

Table 25 shows the impact of all of the changes previously discussed on payments for selected high volume procedures. This table shows the combined impact of changes in RVUs and the physician fee schedule update on total payment for the procedure. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and non−facility practice expense refer to § 414.22(b)(5)(i).

TABLE 25.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

HCPCS	MOD	DESC	Non-Facility			Facility		
			Old	New	% Change	Old	New	% Change
11721	.....	Debride nail, 6 or more	$36.92	$35.28	−4	$28.96	$27.33	−6
17000	.....	Destroy benign/premlg lesion	62.62	57.77	−8	32.94	31.13	−5
27130	.....	Total hip arthroplasty	N/A	N/A	N/A	1,452.31	1,263.30	−13
27236	.....	Treat thigh fracture	N/A	N/A	N/A	1,113.85	1,005.24	−10
27244	.....	Treat thigh fracture	N/A	N/A	N/A	1,137.38	1,086.53	−4
27447	.....	Total knee arthroplasty	N/A	N/A	N/A	1,514.21	1,359.47	−10
33533	.....	CABG, arterial, single	N/A	N/A	N/A	1,827.34	1,691.89	−7
35301	.....	Rechanneling of artery	N/A	N/A	N/A	1,061.36	1,009.74	−5
43239	.....	Upper GI endoscopy, biopsy	354.75	317.55	−10	154.93	146.67	−5
45385	.....	Lesion removal colonoscopy	571.22	513.00	−10	287.78	273.28	−5
66821	.....	After cataract laser surgery	229.50	215.51	−6	213.94	200.29	−6
66984	.....	Cataract surg w/iol, 1 stage	N/A	N/A	N/A	669.32	630.61	−6
67210	.....	Treatment of retinal lesion	603.08	568.35	−6	546.61	515.77	−6
71010	26	Chest x-ray	9.05	8.65	−4	9.05	8.65	−4
71020	26	Chest x-ray	11.22	10.38	−7	11.22	10.38	−7
76091	.....	Mammogram, both breasts	90.50	88.21	−3	N/A	N/A	N/A
76091	26	Mammogram, both breasts	43.44	41.51	−4	43.44	41.51	−4
76092	.....	Mammogram, screening	81.81	77.83	−5	N/A	N/A	N/A
76092	26	Mammogram, screening	35.48	33.90	−4	35.48	33.90	−4
77427	.....	Radiation tx management, 5	167.96	158.09	−6	167.96	158.09	−6
78465	26	Heart image (3d), multiple	74.93	70.91	−5	74.93	70.91	−5
88305	26	Tissue exam by pathologist	40.54	38.40	−5	40.54	38.40	−5
90801	.....	Psy dx interview	144.80	140.10	−3	137.19	132.14	−4
90806	.....	Psytx, off, 45–50 min	95.93	90.63	−6	91.22	87.17	−4

TABLE 25.—IMPACT OF PROPOSED RULE AND PHYSICIAN FEE SCHEDULE UPDATE ON MEDICARE PAYMENT FOR SELECTED PROCEDURES

HCPCS	MOD	DESC	Non-Facility			Facility		
			Old	New	% Change	Old	New	% Change
90807	.....	Psytx, off, 45–50 min w/e&m	103.53	96.51	−7	98.82	94.09	−5
90862	.....	Medication management	51.04	47.74	−6	46.33	44.97	−3
90921	.....	ESRD related services, month	273.30	246.64	−10	273.30	246.64	−10
90935	.....	Hemodialysis, one evaluation	N/A	N/A	N/A	76.38	67.11	−12
92004	.....	Eye exam, new patient	123.44	116.23	−6	87.96	83.02	−6
92012	.....	Eye exam established pat	61.18	57.77	−6	35.84	33.90	−5
92014	.....	Eye exam & treatment	91.22	85.44	−6	58.64	55.35	−6
92980	.....	Insert intracoronary stent	N/A	N/A	N/A	788.06	752.72	−4
92982	.....	Coronary artery dilation	N/A	N/A	N/A	582.45	559.01	−4
93000	.....	Electrocardiogram, complete	25.34	24.91	−2	N/A	N/A	N/A
93010	.....	Electrocardiogram report	9.05	8.30	−8	9.05	8.30	−8
93015	.....	Cardiovascular stress test	99.91	97.55	−2	N/A	N/A	N/A
93307	26	Echo exam of heart	48.14	45.32	−6	48.14	45.32	−6
93510	26	Left heart catheterization	230.59	217.58	−6	230.59	217.58	−6
98941	.....	Chiropractic manipulation	35.48	33.55	−5	31.13	29.40	−6
99202	.....	Office/outpatient visit, new	61.54	58.81	−4	45.61	43.24	−5
99203	.....	Office/outpatient visit, new	91.95	87.17	−5	69.50	66.07	−5
99204	.....	Office/outpatient visit, new	130.68	124.19	−5	102.81	97.55	−5
99205	.....	Office/outpatient visit, new	166.15	158.43	−5	136.47	129.37	−5
99211	.....	Office/outpatient visit, est	20.27	19.37	−4	8.69	8.30	−4
99212	.....	Office/outpatient visit, est	36.20	34.25	−5	23.17	21.79	−6
99213	.....	Office/outpatient visit, est	50.32	48.08	−4	34.03	32.52	−4
99214	.....	Office/outpatient visit, est	78.91	75.06	−5	56.11	53.27	−5
99215	.....	Office/outpatient visit, est	115.84	110.00	−5	90.50	85.79	−5
99221	.....	Initial hospital care	N/A	N/A	N/A	65.16	61.92	−5
99222	.....	Initial hospital care	N/A	N/A	N/A	108.24	102.74	−5
99223	.....	Initial hospital care	N/A	N/A	N/A	150.95	142.86	−5
99231	.....	Subsequent hospital care	N/A	N/A	N/A	32.58	30.79	−5
99232	.....	Subsequent hospital care	N/A	N/A	N/A	53.57	50.85	−5
99233	.....	Subsequent hospital care	N/A	N/A	N/A	76.38	72.30	−5
99236	.....	Observ/hosp same date	N/A	N/A	N/A	214.66	203.75	−5
99238	.....	Hospital discharge day	N/A	N/A	N/A	66.24	65.03	−2
99239	.....	Hospital discharge day	N/A	N/A	N/A	90.86	88.21	−3
99241	.....	Office consultation	47.06	44.62	−5	33.30	31.13	−7
99242	.....	Office consultation	87.24	83.02	−5	68.05	64.00	−6
99243	.....	Office consultation	115.84	109.66	−5	90.14	85.10	−6
99244	.....	Office consultation	164.34	156.01	−5	133.58	126.26	−5
99245	.....	Office consultation	212.85	202.36	−5	177.01	167.08	−6
99251	.....	Initial inpatient consult	N/A	N/A	N/A	34.75	32.86	−5
99252	.....	Initial inpatient consult	N/A	N/A	N/A	69.86	66.07	−5
99253	.....	Initial inpatient consult	N/A	N/A	N/A	95.20	90.29	−5
99254	.....	Initial inpatient consult	N/A	N/A	N/A	136.83	129.72	−5
99255	.....	Initial inpatient consult	N/A	N/A	N/A	188.60	178.49	−5
99261	.....	Follow−up inpatient consult	N/A	N/A	N/A	21.72	20.76	−4
99262	.....	Follow−up inpatient consult	N/A	N/A	N/A	43.44	41.16	−5
99263	.....	Follow−up inpatient consult	N/A	N/A	N/A	64.80	61.23	−6
99282	.....	Emergency dept visit	N/A	N/A	N/A	26.43	25.25	−4
99283	.....	Emergency dept visit	N/A	N/A	N/A	59.37	56.73	−4
99284	.....	Emergency dept visit	N/A	N/A	N/A	92.67	88.56	−4
99285	.....	Emergency dept visit	N/A	N/A	N/A	144.80	138.02	−5
99291	.....	Critical care, first hour	208.87	197.52	−5	198.37	188.18	−5
99292	.....	Critical care, addl 30 min	108.24	101.35	−6	98.82	94.09	−5
99301	.....	Nursing facility care	70.23	66.76	−5	60.09	57.42	−4
99302	.....	Nursing facility care	95.57	90.98	−5	80.72	76.45	−5
99303	.....	Nursing facility care	118.73	112.77	−5	100.27	95.13	−5
99311	.....	Nursing fac care, subseq	40.18	38.40	−4	30.05	28.71	−4
99312	.....	Nursing fac care, subseq	61.90	58.81	−5	49.95	47.39	−5
99313	.....	Nursing fac care, subseq	84.34	80.60	−4	70.95	67.45	−5
99348	.....	Home visit, est patient	73.85	69.88	−5	N/A	N/A	N/A
99350	.....	Home visit, est patient	166.52	157.74	−5	N/A	N/A	N/A
G0008	.....	Admin influenza virus vac	3.98	7.26	82	N/A	N/A	N/A
G0009	.....	Admin pneumococcal vaccine	3.98	7.26	82	N/A	N/A	N/A
G0010	.....	Admin hepatitis b vaccine	3.98	7.26	82	N/A	N/A	N/A

B. Proposed Productivity Adjustment to the MEI

As indicated in section VI.B. of this final rule, we are adopting the proposed change to the methodology for adjusting for productivity in the MEI. We will use the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity applied to the entire index to calculate the MEI beginning in CY 2003. The prior method accounted for productivity by adjusting the labor portion of the MEI by the 10-year moving average change in private nonfarm business (economy-wide) labor productivity. Our reasons for proposing this change and the alternatives we considered are discussed in detail in section VI.

We believe that we have developed a revised MEI methodology that is technically superior to the current MEI and more adequately reflects annual changes in the cost of furnishing services in efficient physicians' practices. The change to the MEI will

raise the index by 0.7 percentage points from 2.3 percent to 3.0 percent for 2003. We estimate that this change will increase Federal expenditures by $150 million in FY 2003. The outyear impact is a function of numerous economic variables that fluctuate unpredictably. Our estimate of the impact beyond FY 2003 is based on projections of both the current and revised index. We estimate the change would increase Federal expenditures by $340 million in FY 2004 and $550 million in FY 2005.

C. Site of Service

Relative values for practice expense are determined for both ''facility'' and ''non-facility'' settings. (*See* Addendum B.) We are clarifying whether a given place of service is either a facility or non-facility site for purposes of determining Medicare payment. This clarification should benefit physicians, providers, and Medicare contractors by making the payment rules clearer. We are updating the facility and non-facility designations for several new place-of-service codes and changing the designations for several already in existence. The update for the new place-of-service codes will have no effect on Medicare spending. The place-of-service codes in which we are changing the designation are infrequently used for physician fee schedule services. This rule could result in a minor redistribution in payment among physician fee schedule services through the practice expense budget-neutrality adjustments.

D. Pricing of Technical Components (TC) for Positron Emission Tomography (PET) Scans

As stated earlier, to keep pricing consistent with the manner in which other PET scan services are paid, we are changing from national pricing to carrier pricing for the TC and global value for HCPCS code G0125 *Lung Image PET scans.* The budgetary impact on the Medicare program and providers would be uncertain since we do not know the payment amounts that carriers would use for this service.

E. Medicare Qualifications for Clinical Nurse Specialists (CNSs)

As previously stated, we are revising regulations regarding qualifications for CNSs by allowing flexibility as to certifying bodies. We believe this change will make the Medicare requirements more consistent with criteria for nurse practitioners. We also believe there will be additional enrollment of CNSs that will qualify for Medicare enrollment. We expect that this policy will have little effect on Medicare expenditures.

F. Process To Add or Delete Services to the Definition of Telehealth

We are finalizing a process for adding or deleting services from the list of telehealth services. In addition, we are adding psychiatric diagnostic interview examinations, CPT code 90801, to the list of Medicare telehealth services. We believe this will have little effect on Medicare expenditures.

G. Change in Global Period for CPT code 77789 (Surface Application of Radiation Source

We are changing the global period for CPT code 77789 (surface application of radiation source) from a 90-day global period to a 000-day global period. We believe physicians that furnish these services will benefit from this change because it will simplify their billing processes. We do not expect it will have a significant impact on the Medicare program because the change will reflect current practices.

H. New HCPCS G-Codes

In section K we discuss new G-codes for—treatment of peripheral neuropathy; current perception sensory nerve conduction threshold tests; PET codes for breast imaging; and home prothrombin time INR monitoring for anticoagulation management. We have withdrawn our proposal for a new G code for bone marrow aspiration and biopsy on the same date of service. All G codes except for the G code for bone marrow aspiration and biopsy on the same date of service have been implemented during CY 2002 through Program Memoranda as a result of national coverage decisions or the need to clarify payment policy. As stated, we are not proceeding with a G code for bone marrow aspiration and biopsy on the same date of service.

I. Endoscopic Base For Urology Codes

We are correcting the pricing of certain endoscopic services. As we previously indicated, we will use CPT procedure code 52000 as the endoscopic base code for CPT procedure codes 52234, 52235, and 52240. This will result in a reduction in payment in instances when these codes are billed in conjunction with either CPT procedure code 52000 or other codes that have CPT procedure code 52000 as the endscopic base code. We expect the savings will be negligible.

J. Physical Therapy and Occupational Therapy Caps

There were no proposals made in this area. The imposition of the physical and occupational therapy caps will occur as a result of application of section 4541(c) of the BBA. While section 221 of the BBRA and section 421 of BIPA placed a moratorium on application of these caps, the moratorium expires for physical and occupational therapy services furnished after December 31, 2002. We estimate that application of the caps will reduce Medicare expenditures for physical and occupational therapy services by $240 million in CY 2003.

K. Enrollment of Physical and Occupational Therapists as Therapists in Private Practice

This change will provide flexibility for therapists by allowing therapists that meet the enrollment criteria to enroll in Medicare without regard to how they are organized to provide services. We do not expect this will have a significant effect on Medicare expenditures because Medicare pays the same amount for these therapy services whether they are billed directly by a therapist or by a physician as an incident to service.

L. Screening Fecal Occult Blood Tests

As discussed in section II.N (1) of the preamble, we are modifying our regulations to allow us to expand coverage when appropriate for (1) screening fecal-occult blood tests for the early detection of colorectal cancer, and (2) additional colorectal cancer screening tests through our national coverage determination process. These changes will allow us to conduct more timely assessments of new types of colon cancer screening tests than is normally possible under the standard rulemaking process. There are no costs or savings to the Medicare program associated with this regulation change.

M. Add-on Anesthesia Codes

The add-on codes, two for obstetrical anesthesia (CPT codes 01968 and 01969) and one for burn excisions (CPT code 01953), represent low volume codes for the Medicare population. We believe the new policy for add-on codes will have a negligible impact on total anesthesia payments.

N. Physician Self-Referral Prohibitions

As discussed in section IV of this preamble, we are updating the list of codes used to define certain designated health services for the purposes of section 1877 of the Act. We are not making any substantive change to the description of any designated health

service as set forth in the January 4, 2001 physician self-referral final rule (66 FR 856). Instead, we are merely updating our list of codes to conform to coding changes in the most recent publication of CPT and HCPCS codes.

For this reason, we certify that the changes we are making will not have a significant economic effect on a substantial number of small entities or on the operations of a substantial number of small rural hospitals.

O. Critical Access Hospital Emergency Services Requirement

We anticipate that this rule will reduce cost for small CAHs. Frontier area and remote location CAHs will no longer be limited to hiring only a physician, nurse practitioner or physician assistant to provide emergency coverage in the absence of the sole practitioner. This rule will provide relief to small CAHs in meeting the current emergency staffing requirement by allowing them to utilize a registered nurse to provide emergency care services once the State submits a letter to us, signed by the Governor, following consultation with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that RNs be included as emergency personnel in § 485.618(d).

P. Alternatives Considered

This final rule contains a range of policies. The preamble identifies those policies when discretion has been exercised and presents rationale for our decisions, including a presentation of nonselected options (except for the critical access hospital emergency services requirement which is provided separately).

Critical Access Hospitals Emergency Services Personnel Requirement

We considered allowing each CAH in a frontier area or remote location to individually request a waiver of the requirements at § 485.618(a) and (d). The statute does not provide authority to waive the requirement for continuous emergency room coverage. Section 1820(c)(B)(ii) requires a qualifying CAH to make available the 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a CAH. However, we believe States may interpret emergency care services to allow CAHs to use a RN in order to comply with the emergency services personnel requirement stated in the regulations at § 485.618. This change is consistent with our policy of respecting State oversight of health care professions by deferring to State law to regulate professional practice.

Q. Impact on Beneficiaries

Although changes in physicians' payments were large when the physician fee schedule was implemented in 1992, we detected no problems with beneficiary access to care. We do not believe that there would be any problem with access to care as a result of the changes in this rule. While it has been suggested that the negative update for CY 2003 may affect beneficiary access to care, we note that the formula to determine this update is set by statute and this regulation cannot, and does not, change it.

As indicated above, the imposition of the physical and occupational therapy caps will occur as a result of application of section 4541(c) of the BBA. It is possible that application of physical and occupational therapy caps will have an impact on Medicare beneficiaries either through increased liability for services exceeding the cap or fewer services being provided. We contracted with the Urban Institute to perform analyses related to the implementation of the therapy caps, based on an analysis of a sample of therapy services provided from CYs 1998 through 2000. The draft reports are available on the CMS website. The contractor report indicated that in CY 2000, about 12 percent of patients who received therapy services would have exceeded the caps. The caps are more likely to be exceeded in skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and other rehabilitation facility settings. The caps do not apply to outpatient therapy services provided in an outpatient hospital. The report does not make assumptions about changes in behavior in response to the caps. Without more experience with the caps, it is difficult to predict the precise impact on beneficiaries.

In addition, CAHs in frontier areas and remote locations will be able to satisfy the CAH emergency services personnel requirement, through the addition of RNs to our personnel requirements and beneficiaries will have greater access to care through the utilization of RNs providing emergency care services to patients.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this regulation.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 410.37, paragraphs (a)(1)(v) and (a)(2) are revised to read as follows:

§ 410.37 Colorectal cancer screening tests: Conditions for and limitations on coverage.

(a) * * *

(1) * * *

(v) Other tests or procedures established by a national coverage determination, and modifications to tests under this paragraph, with such frequency and payment limits as CMS determines appropriate, in consultation with appropriate organizations

(2) *Screening fecal-occult blood test* means—

(i) A guaiac-based test for peroxidase activity, testing two samples from each of three consecutive stools, or,

(ii) Other tests as determined by the Secretary through a national coverage determination.

* * * * *

3. Section 410.59 is amended as follows:

A. Paragraph (c)(1)(ii)(C) is revised.

B. A new paragraph (c)(1)(ii)(D) is added.

C. A new paragraph (c)(1)(ii)(E) is added.

The revision and additions read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

* * * * *

(c) * * *
(1) * * *
(ii) * * *
(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated occupational therapy practice.
(D) An employee of a physician group.
(E) An employee of a group that is not a professional corporation.
* * * * *

4. Section 410.60 is amended as follows:
A. Paragraph (c)(1)(ii)(C) is revised.
B. A new paragraph (c)(1)(ii)(D) is added.
C. A new paragraph (c)(1)(ii)(E) is added
The revision and additions read as follows:

§ 410.60 Outpatient physical therapy services: Conditions

* * * * *
(c) * * *
(1) * * *
(ii) * * *
(C) An unincorporated solo practice, partnership, or group practice, or a professional corporation or other incorporated physical therapy practice.
(D) An employee of a physician group.
(E) An employee of a group that is not a professional corporation.
* * * * *

5. Section 410.61 is amended by revising paragraph (d)(1)(iii) to read as follows:

§ 410.61 Plan of treatment requirements for outpatient rehabilitation services.

(d) * * *
(1) * * *
(iii) The occupational therapist that furnishes the occupational therapy services.
* * * * *

6. Section 410.76 is amended by revising paragraph (b)(3) to read as follows:

§ 410.76 Clinical nurse specialists' services.

* * * * *
(b) * * *
(3) Be certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.
* * * * *

7. Section 410.78 is amended as follows:
a. Revise the heading of the section.
b. Revise the introductory text of paragraph (b).
c. Revise paragraph (b)(1).
d. Add a new paragraph (f).
The revisions and additions read as follows:

§ 410.78 Telehealth services.

* * * * *
(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, and pharmacologic management furnished by an interactive telecommunications system if the following conditions are met:
(1) The physician or practitioner at the distant site must be licensed to furnish the service under State law. The physician or practitioner at the distant site who is licensed under State law to furnish a covered telehealth service described in this section may bill, and receive payment for, the service when it is delivered via a telecommunications system.
* * * * *
(f) *Process for adding or deleting services.* Changes to the list of Medicare telehealth services are made through the annual physician fee schedule rulemaking process.

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

1. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

2. Section 414.46 is amended by revising paragraph (g) to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *
(g) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services. The carrier makes payment for add-on anesthesia codes according to program operating instructions.

3. Section 414.65, is amended as follows:
a. Revise the heading of the section.
b. Revise paragraph (a)(1).
c. Revise paragraph (b) introductory text.
The revisions read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *
(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, and pharmacologic management furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.
* * * * *
(b) *Originating site facility fee.* For telehealth services furnished on or after October 1, 2001:
* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

Part 485 is amended as set forth below:

1. The authority citation for 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Act (42 U.S.C. 1302 and 1396hh).

2. Section 485.618 is amended by revising paragraph (d) to read as follows:

§ 485.618 Condition of participation: Emergency services.

* * * * *
(d) *Standard: Personnel.* (1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner, with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:
(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or
(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:
(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.
(B) The State has determined, under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

(2) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if—

(i) The CAH has no greater than 10 beds;

(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;

(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;

(iv) Once a Governor submits a letter, as specified in paragraph (d)(2)(ii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in this paragraph (d).

(3) The request, as specified in paragraph(d)(2)(ii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 26, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: December 12, 2002.

Tommy G. Thompson,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2003. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alpha-numeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2003 Relative Value Units and Related Information Used in Determining Medicare Payments for 2003

This addendum contains the following information for each CPT code and alphanumeric HCPCS code for services that may be paid under the physician fee schedule as well as all G codes

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: One for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

D = Deleted code. These codes are deleted effective with the beginning of the calendar year.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

F = Deleted/discontinued codes. Code not subject to a 90-day grace period.

G = Code not valid for Medicare purposes. Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services.

H = Deleted modifier. Either the TC or PC component shown for the code has been deleted, and the deleted component is shown in the data base with the H status indicator. (Code subject to a 90-day grace period.)

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Code NOT subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's

service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2003. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings. An ''NA'' in the facility column means that we do not pay for the service in a facility setting. For instance, we do not pay using the physician fee schedule for the global or technical component of a radiology service or other diagnostic test in a facility setting. Also, there is no payment in a facility setting for ''incident to'' services (services that do not have physician work RVUs). Payment is included in our payment for institutional services.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings. An ''NA'' in the nonfacility column means that the service is generally not provided outside of hospitals and we do not have information upon which to determine a price. In most cases, these are major surgical services.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2003.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra service time and in some instances the pre- and post-service time.)

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
0001T		C	Endovas repr abdo ao aneurys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0002T		C	Endovas repr abdo ao aneurys	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0003T		C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0005T		C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0006T		C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0007T		C	Perc cath stent/brain cv art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T		C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0009T		C	Endometrial cryoablation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T		C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0012T		C	Osteochondral knee autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0013T		C	Osteochondral knee allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0014T		C	Meniscal transplant, knee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T		C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T		A	Extracorp shock wave tx, ft	0.06	1.46	0.02	0.01	1.53	0.09	XXX
0021T		C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T		C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T		C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0025T		C	Ultrasonic pachymetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0033T		C	Endovasc taa repr incl subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0034T		C	Endovasc taa repr w/o subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0035T		C	Insert endovasc prosth, taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0036T		C	Endovasc prosth, taa, add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0037T		C	Artery transpose/endovas taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0038T		C	Rad endovasc taa rpr w/cover	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0039T		C	Rad s/i, endovasc taa repair	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0040T		C	Rad s/i, endovasc taa prosth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.37	NA	0.07	3.71	NA	XXX
10022		A	Fna w/image	1.27	2.66	NA	0.05	3.98	NA	XXX
10040		A	Acne surgery	1.18	1.10	0.71	0.05	2.33	1.94	010
10060		A	Drainage of skin abscess	1.17	1.49	0.67	0.08	2.74	1.92	010
10061		A	Drainage of skin abscess	2.40	1.88	1.41	0.17	4.45	3.98	010
10080		A	Drainage of pilonidal cyst	1.17	2.13	0.73	0.09	3.39	1.99	010
10081		A	Drainage of pilonidal cyst	2.45	2.90	1.55	0.19	5.54	4.19	010
10120		A	Remove foreign body	1.22	1.54	0.36	0.10	2.86	1.68	010
10121		A	Remove foreign body	2.69	2.96	1.79	0.25	5.90	4.73	010
10140		A	Drainage of hematoma/fluid	1.53	1.49	0.87	0.15	3.17	2.55	010
10160		A	Puncture drainage of lesion	1.20	0.77	0.42	0.11	2.08	1.73	010
10180		A	Complex drainage, wound	2.25	1.48	1.27	0.25	3.98	3.77	010
11000		A	Debride infected skin	0.60	0.64	0.24	0.05	1.29	0.89	000
11001		A	Debride infected skin add-on	0.30	0.38	0.11	0.02	0.70	0.43	ZZZ
11010		A	Debride skin, fx	4.20	2.40	1.96	0.45	7.05	6.61	010
11011		A	Debride skin/muscle, fx	4.95	3.83	2.60	0.53	9.31	8.08	000
11012		A	Debride skin/muscle/bone, fx	6.88	5.51	4.23	0.89	13.28	12.00	000
11040		A	Debride skin, partial	0.50	0.52	0.21	0.05	1.07	0.76	000
11041		A	Debride skin, full	0.82	0.66	0.33	0.06	1.54	1.21	000
11042		A	Debride skin/tissue	1.12	0.97	0.47	0.09	2.18	1.68	000
11043		A	Debride tissue/muscle	2.38	3.57	2.64	0.24	6.19	5.26	010
11044		A	Debride tissue/muscle/bone	3.06	4.73	3.91	0.34	8.13	7.31	010
11055		R	Trim skin lesion	0.43	0.51	0.18	0.02	0.96	0.63	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.58	0.26	0.03	1.22	0.90	000
11057		R	Trim skin lesions, over 4	0.79	0.65	0.33	0.04	1.48	1.16	000
11100		A	Biopsy of skin lesion	0.81	1.24	0.38	0.04	2.09	1.23	000
11101		A	Biopsy, skin add-on	0.41	0.38	0.20	0.02	0.81	0.63	ZZZ
11200		A	Removal of skin tags	0.77	1.23	0.31	0.04	2.04	1.12	010
11201		A	Remove skin tags add-on	0.29	0.56	0.12	0.02	0.87	0.43	ZZZ
11300		A	Shave skin lesion	0.51	0.99	0.22	0.03	1.53	0.76	000
11301		A	Shave skin lesion	0.85	1.10	0.39	0.04	1.99	1.28	000

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
11302	.....	A	Shave skin lesion	1.05	1.30	0.48	0.05	2.40	1.58	000
11303	.....	A	Shave skin lesion	1.24	1.59	0.54	0.06	2.89	1.84	000
11305	.....	A	Shave skin lesion	0.67	0.84	0.27	0.04	1.55	0.98	000
11306	.....	A	Shave skin lesion	0.99	1.10	0.43	0.05	2.14	1.47	000
11307	.....	A	Shave skin lesion	1.14	1.29	0.50	0.05	2.48	1.69	000
11308	.....	A	Shave skin lesion	1.41	1.45	0.61	0.07	2.93	2.09	000
11310	.....	A	Shave skin lesion	0.73	1.11	0.33	0.04	1.88	1.10	000
11311	.....	A	Shave skin lesion	1.05	1.23	0.50	0.05	2.33	1.60	000
11312	.....	A	Shave skin lesion	1.20	1.43	0.57	0.06	2.69	1.83	000
11313	.....	A	Shave skin lesion	1.62	1.81	0.74	0.09	3.52	2.45	000
11400	.....	A	Exc tr-ext b9+marg 0.5 < cm	0.85	2.08	0.96	0.06	2.99	1.87	010
11401	.....	A	Exc tr-ext b9+marg 0.6-1 cm	1.23	2.12	1.08	0.09	3.44	2.40	010
11402	.....	A	Exc tr-ext b9+marg 1.1-2 cm	1.51	2.28	1.14	0.12	3.91	2.77	010
11403	.....	A	Exc tr-ext b9+marg 2.1-3 cm	1.79	2.50	1.35	0.16	4.45	3.30	010
11404	.....	A	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.84	1.42	0.18	5.08	3.66	010
11406	.....	A	Exc tr-ext b9+marg > 4.0 cm	2.76	3.24	1.68	0.25	6.25	4.69	010
11420	.....	A	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.81	1.00	0.08	2.87	2.06	010
11421	.....	A	Exc h-f-nk-sp b9+marg 0.6-1	1.42	2.12	1.18	0.11	3.65	2.71	010
11422	.....	A	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.30	1.38	0.14	4.07	3.15	010
11423	.....	A	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.66	1.49	0.17	4.84	3.67	010
11424	.....	A	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.93	1.64	0.21	5.57	4.28	010
11426	.....	A	Exc h-f-nk-sp b9+marg > 4 cm	3.78	3.75	2.15	0.34	7.87	6.27	010
11440	.....	A	Exc face-mm b9+marg 0.5 < cm	1.06	2.27	1.41	0.08	3.41	2.55	010
11441	.....	A	Exc face-mm b9+marg 0.6-1 cm	1.48	2.40	1.59	0.11	3.99	3.18	010
11442	.....	A	Exc face-mm b9+marg 1.1-2 cm	1.72	2.66	1.66	0.14	4.52	3.52	010
11443	.....	A	Exc face-mm b9+marg 2.1-3 cm	2.29	3.04	1.90	0.18	5.51	4.37	010
11444	.....	A	Exc face-mm b9+marg 3.1-4 cm	3.14	3.64	2.28	0.25	7.03	5.67	010
11446	.....	A	Exc face-mm b9+marg > 4 cm	4.49	4.26	2.88	0.30	9.05	7.67	010
11450	.....	A	Removal, sweat gland lesion	2.73	4.12	0.98	0.26	7.11	3.97	090
11451	.....	A	Removal, sweat gland lesion	3.95	4.98	1.43	0.39	9.32	5.77	090
11462	.....	A	Removal, sweat gland lesion	2.51	4.10	0.95	0.23	6.84	3.69	090
11463	.....	A	Removal, sweat gland lesion	3.95	5.60	1.57	0.40	9.95	5.92	090
11470	.....	A	Removal, sweat gland lesion	3.25	4.54	1.23	0.30	8.09	4.78	090
11471	.....	A	Removal, sweat gland lesion	4.41	5.69	1.72	0.40	10.50	6.53	090
11600	.....	A	Exc tr-ext mlg+marg 0.5 < cm	1.31	2.53	0.99	0.09	3.93	2.39	010
11601	.....	A	Exc tr-ext mlg+marg 0.6-1 cm	1.80	2.60	1.24	0.12	4.52	3.16	010
11602	.....	A	Exc tr-ext mlg+marg 1.1-2 cm	1.95	2.73	1.29	0.13	4.81	3.37	010
11603	.....	A	Exc tr-ext mlg+marg 2.1-3 cm	2.19	2.96	1.35	0.16	5.31	3.70	010
11604	.....	A	Exc tr-ext mlg+marg 3.1-4 cm	2.40	3.27	1.41	0.18	5.85	3.99	010
11606	.....	A	Exc tr-ext mlg+marg > 4 cm	3.43	3.96	1.76	0.28	7.67	5.47	010
11620	.....	A	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	2.49	0.97	0.09	3.77	2.25	010
11621	.....	A	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.60	1.27	0.12	4.48	3.15	010
11622	.....	A	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.87	1.42	0.15	5.11	3.66	010
11623	.....	A	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.22	1.62	0.20	6.03	4.43	010
11624	.....	A	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.61	1.81	0.25	6.92	5.12	010
11626	.....	A	Exc h-f-nk-sp mlg+mar > 4 cm	4.30	4.56	2.44	0.35	9.21	7.09	010
11640	.....	A	Exc face-mm malig+marg 0.5 <	1.35	2.54	1.14	0.10	3.99	2.59	010
11641	.....	A	Exc face-mm malig+marg 0.6-1	2.16	2.92	1.57	0.15	5.23	3.88	010
11642	.....	A	Exc face-mm malig+marg 1.1-2	2.59	3.30	1.77	0.18	6.07	4.54	010
11643	.....	A	Exc face-mm malig+marg 2.1-3	3.10	3.70	2.01	0.24	7.04	5.35	010
11644	.....	A	Exc face-mm malig+marg 3.1-4	4.03	4.63	2.56	0.33	8.99	6.92	010
11646	.....	A	Exc face-mm mlg+marg > 4 cm	5.95	5.73	3.60	0.46	12.14	10.01	010
11719	.....	R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
11720	.....	A	Debride nail, 1-5	0.32	0.34	0.13	0.02	0.68	0.47	000
11721	.....	A	Debride nail, 6 or more	0.54	0.44	0.21	0.04	1.02	0.79	000
11730	.....	A	Removal of nail plate	1.13	0.81	0.44	0.09	2.03	1.66	000
11732	.....	A	Remove nail plate, add-on	0.57	0.30	0.23	0.05	0.92	0.85	ZZZ
11740	.....	A	Drain blood from under nail	0.37	0.82	0.14	0.03	1.22	0.54	000
11750	.....	A	Removal of nail bed	1.86	1.72	0.77	0.16	3.74	2.79	010
11752	.....	A	Remove nail bed/finger tip	2.67	2.11	1.76	0.33	5.11	4.76	010
11755	.....	A	Biopsy, nail unit	1.31	1.11	0.56	0.06	2.48	1.93	000
11760	.....	A	Repair of nail bed	1.58	1.80	1.25	0.17	3.55	3.00	010
11762	.....	A	Reconstruction of nail bed	2.89	2.24	1.88	0.32	5.45	5.09	010
11765	.....	A	Excision of nail fold, toe	0.69	1.13	0.49	0.05	1.87	1.23	010
11770	.....	A	Removal of pilonidal lesion	2.61	2.98	1.23	0.24	5.83	4.08	010
11771	.....	A	Removal of pilonidal lesion	5.74	5.50	3.91	0.56	11.80	10.21	090
11772	.....	A	Removal of pilonidal lesion	6.98	6.41	4.36	0.68	14.07	12.02	090
11900	.....	A	Injection into skin lesions	0.52	0.75	0.22	0.02	1.29	0.76	000
11901	.....	A	Added skin lesions injection	0.80	0.72	0.36	0.03	1.55	1.19	000
11920	.....	R	Correct skin color defects	1.61	2.16	0.80	0.17	3.94	2.58	000
11921	.....	R	Correct skin color defects	1.93	2.52	1.00	0.21	4.66	3.14	000
11922	.....	R	Correct skin color defects	0.49	0.38	0.26	0.05	0.92	0.80	ZZZ
11950	.....	R	Therapy for contour defects	0.84	1.22	0.42	0.06	2.12	1.32	000
11951	.....	R	Therapy for contour defects	1.19	1.61	0.52	0.10	2.90	1.81	000
11952	.....	R	Therapy for contour defects	1.69	1.97	0.70	0.17	3.83	2.56	000

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
11954	.....	R	Therapy for contour defects	1.85	2.59	0.93	0.19	4.63	2.97	000
11960	.....	A	Insert tissue expander(s)	9.08	NA	10.94	0.88	NA	20.90	090
11970	.....	A	Replace tissue expander	7.06	NA	4.98	0.77	NA	12.81	090
11971	.....	A	Remove tissue expander(s)	2.13	6.33	3.86	0.21	8.67	6.20	090
11975	.....	N	Insert contraceptive cap	+1.48	1.44	0.58	0.14	3.06	2.20	XXX
11976	.....	R	Removal of contraceptive cap	1.78	1.62	0.70	0.17	3.57	2.65	000
11977	.....	N	Removal/reinsert contra cap	+3.30	2.30	1.28	0.31	5.91	4.89	XXX
11980	.....	A	Implant hormone pellet(s)	1.48	1.07	0.56	0.10	2.65	2.14	000
11981	.....	A	Insert drug implant device	1.48	1.59	0.58	0.14	3.21	2.20	XXX
11982	.....	A	Remove drug implant device	1.78	1.71	0.70	0.17	3.66	2.65	XXX
11983	.....	A	Remove/insert drug implant	3.30	2.30	1.28	0.31	5.91	4.89	XXX
12001	.....	A	Repair superficial wound(s)	1.70	2.16	0.44	0.13	3.99	2.27	010
12002	.....	A	Repair superficial wound(s)	1.86	2.23	0.92	0.15	4.24	2.93	010
12004	.....	A	Repair superficial wound(s)	2.24	2.51	1.03	0.17	4.92	3.44	010
12005	.....	A	Repair superficial wound(s)	2.86	3.07	1.22	0.23	6.16	4.31	010
12006	.....	A	Repair superficial wound(s)	3.67	3.69	1.53	0.31	7.67	5.51	010
12007	.....	A	Repair superficial wound(s)	4.12	4.16	1.83	0.37	8.65	6.32	010
12011	.....	A	Repair superficial wound(s)	1.76	2.34	0.44	0.14	4.24	2.34	010
12013	.....	A	Repair superficial wound(s)	1.99	2.49	0.96	0.16	4.64	3.11	010
12014	.....	A	Repair superficial wound(s)	2.46	2.77	1.08	0.18	5.41	3.72	010
12015	.....	A	Repair superficial wound(s)	3.19	3.38	1.27	0.24	6.81	4.70	010
12016	.....	A	Repair superficial wound(s)	3.93	3.81	1.55	0.32	8.06	5.80	010
12017	.....	A	Repair superficial wound(s)	4.71	NA	1.90	0.39	NA	7.00	010
12018	.....	A	Repair superficial wound(s)	5.53	NA	2.27	0.46	NA	8.26	010
12020	.....	A	Closure of split wound	2.62	2.55	1.42	0.24	5.41	4.28	010
12021	.....	A	Closure of split wound	1.84	1.70	1.02	0.19	3.73	3.05	010
12031	.....	A	Layer closure of wound(s)	2.15	2.29	0.77	0.15	4.59	3.07	010
12032	.....	A	Layer closure of wound(s)	2.47	2.98	1.28	0.15	5.60	3.90	010
12034	.....	A	Layer closure of wound(s)	2.92	3.21	1.44	0.21	6.34	4.57	010
12035	.....	A	Layer closure of wound(s)	3.43	3.15	1.67	0.30	6.88	5.40	010
12036	.....	A	Layer closure of wound(s)	4.05	5.26	2.46	0.41	9.72	6.92	010
12037	.....	A	Layer closure of wound(s)	4.67	5.62	2.80	0.49	10.78	7.96	010
12041	.....	A	Layer closure of wound(s)	2.37	2.48	0.83	0.17	5.02	3.37	010
12042	.....	A	Layer closure of wound(s)	2.74	3.17	1.41	0.17	6.08	4.32	010
12044	.....	A	Layer closure of wound(s)	3.14	3.26	1.60	0.24	6.64	4.98	010
12045	.....	A	Layer closure of wound(s)	3.64	3.58	1.87	0.34	7.56	5.85	010
12046	.....	A	Layer closure of wound(s)	4.25	5.53	2.55	0.40	10.18	7.20	010
12047	.....	A	Layer closure of wound(s)	4.65	6.15	2.89	0.41	11.21	7.95	010
12051	.....	A	Layer closure of wound(s)	2.47	3.16	1.41	0.16	5.79	4.04	010
12052	.....	A	Layer closure of wound(s)	2.77	3.12	1.38	0.17	6.06	4.32	010
12053	.....	A	Layer closure of wound(s)	3.12	3.26	1.54	0.20	6.58	4.86	010
12054	.....	A	Layer closure of wound(s)	3.46	3.60	1.64	0.25	7.31	5.35	010
12055	.....	A	Layer closure of wound(s)	4.43	4.60	2.19	0.35	9.38	6.97	010
12056	.....	A	Layer closure of wound(s)	5.24	6.62	3.05	0.43	12.29	8.72	010
12057	.....	A	Layer closure of wound(s)	5.96	6.14	3.73	0.50	12.60	10.19	010
13100	.....	A	Repair of wound or lesion	3.12	3.50	1.84	0.21	6.83	5.17	010
13101	.....	A	Repair of wound or lesion	3.92	3.76	2.29	0.22	7.90	6.43	010
13102	.....	A	Repair wound/lesion add-on	1.24	0.76	0.58	0.10	2.10	1.92	ZZZ
13120	.....	A	Repair of wound or lesion	3.30	3.60	1.88	0.23	7.13	5.41	010
13121	.....	A	Repair of wound or lesion	4.33	3.99	2.39	0.25	8.57	6.97	010
13122	.....	A	Repair wound/lesion add-on	1.44	0.89	0.65	0.12	2.45	2.21	ZZZ
13131	.....	A	Repair of wound or lesion	3.79	3.88	2.21	0.25	7.92	6.25	010
13132	.....	A	Repair of wound or lesion	5.95	4.72	3.25	0.32	10.99	9.52	010
13133	.....	A	Repair wound/lesion add-on	2.19	1.22	1.05	0.17	3.58	3.41	ZZZ
13150	.....	A	Repair of wound or lesion	3.81	5.29	2.64	0.29	9.39	6.74	010
13151	.....	A	Repair of wound or lesion	4.45	5.27	3.08	0.28	10.00	7.81	010
13152	.....	A	Repair of wound or lesion	6.33	6.01	3.98	0.38	12.72	10.69	010
13153	.....	A	Repair wound/lesion add-on	2.38	1.37	1.16	0.18	3.93	3.72	ZZZ
13160	.....	A	Late closure of wound	10.48	NA	6.33	1.19	NA	18.00	090
14000	.....	A	Skin tissue rearrangement	5.89	7.60	4.65	0.46	13.95	11.00	090
14001	.....	A	Skin tissue rearrangement	8.47	8.94	5.96	0.65	18.06	15.08	090
14020	.....	A	Skin tissue rearrangement	6.59	8.10	5.35	0.50	15.19	12.44	090
14021	.....	A	Skin tissue rearrangement	10.06	9.53	7.12	0.69	20.28	17.87	090
14040	.....	A	Skin tissue rearrangement	7.87	8.77	7.05	0.55	17.19	15.47	090
14041	.....	A	Skin tissue rearrangement	11.49	11.01	8.91	0.71	23.21	21.11	090
14060	.....	A	Skin tissue rearrangement	8.50	9.48	7.84	0.59	18.57	16.93	090
14061	.....	A	Skin tissue rearrangement	12.29	12.05	9.77	0.75	25.09	22.81	090
14300	.....	A	Skin tissue rearrangement	11.76	11.44	9.36	0.88	24.08	22.00	090
14350	.....	A	Skin tissue rearrangement	9.61	NA	6.36	1.09	NA	17.06	090
15000	.....	A	Skin graft	4.00	3.66	2.22	0.37	8.03	6.59	000
15001	.....	A	Skin graft add-on	1.00	1.26	0.42	0.11	2.37	1.53	ZZZ
15050	.....	A	Skin pinch graft	4.30	5.12	3.99	0.46	9.88	8.75	090
15100	.....	A	Skin split graft	9.05	11.70	8.09	0.94	21.69	18.08	090
15101	.....	A	Skin split graft add-on	1.72	3.27	1.48	0.18	5.17	3.38	ZZZ
15120	.....	A	Skin split graft	9.83	10.23	8.03	0.90	20.96	18.76	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
15121	.....	A	Skin split graft add-on	2.67	4.19	1.85	0.27	7.13	4.79	ZZZ
15200	.....	A	Skin full graft	8.03	9.60	5.54	0.73	18.36	14.30	090
15201	.....	A	Skin full graft add-on	1.32	1.05	0.64	0.14	2.51	2.10	ZZZ
15220	.....	A	Skin full graft	7.87	9.74	6.18	0.68	18.29	14.73	090
15221	.....	A	Skin full graft add-on	1.19	0.93	0.58	0.12	2.24	1.89	ZZZ
15240	.....	A	Skin full graft	9.04	9.25	7.01	0.80	19.09	16.85	090
15241	.....	A	Skin full graft add-on	1.86	1.47	0.94	0.17	3.50	2.97	ZZZ
15260	.....	A	Skin full graft	10.06	9.91	8.90	0.63	20.60	19.59	090
15261	.....	A	Skin full graft add-on	2.23	2.91	1.60	0.17	5.31	4.00	ZZZ
15342	.....	A	Cultured skin graft, 25 cm	1.00	2.06	0.75	0.09	3.15	1.84	010
15343	.....	A	Culture skn graft addl 25 cm	0.25	0.26	0.10	0.02	0.53	0.37	ZZZ
15350	.....	A	Skin homograft	4.00	8.44	4.34	0.42	12.86	8.76	090
15351	.....	A	Skin homograft add-on	1.00	0.95	0.41	0.11	2.06	1.52	ZZZ
15400	.....	A	Skin heterograft	4.00	4.84	4.84	0.40	9.24	9.24	090
15401	.....	A	Skin heterograft add-on	1.00	1.25	0.46	0.11	2.36	1.57	ZZZ
15570	.....	A	Form skin pedicle flap	9.21	8.16	6.07	0.96	18.33	16.24	090
15572	.....	A	Form skin pedicle flap	9.27	7.75	5.80	0.93	17.95	16.00	090
15574	.....	A	Form skin pedicle flap	9.88	8.32	6.84	0.92	19.12	17.64	090
15576	.....	A	Form skin pedicle flap	8.69	8.91	6.29	0.72	18.32	15.70	090
15600	.....	A	Skin graft	1.91	6.13	2.34	0.19	8.23	4.44	090
15610	.....	A	Skin graft	2.42	3.39	2.62	0.25	6.06	5.29	090
15620	.....	A	Skin graft	2.94	6.74	3.39	0.28	9.96	6.61	090
15630	.....	A	Skin graft	3.27	6.19	3.66	0.28	9.74	7.21	090
15650	.....	A	Transfer skin pedicle flap	3.97	6.17	3.73	0.36	10.50	8.06	090
15732	.....	A	Muscle-skin graft, head/neck	17.84	NA	12.70	1.50	NA	32.04	090
15734	.....	A	Muscle-skin graft, trunk	17.79	NA	12.73	1.91	NA	32.43	090
15736	.....	A	Muscle-skin graft, arm	16.27	NA	11.81	1.78	NA	29.86	090
15738	.....	A	Muscle-skin graft, leg	17.92	NA	12.25	1.95	NA	32.12	090
15740	.....	A	Island pedicle flap graft	10.25	9.00	7.05	0.62	19.87	17.92	090
15750	.....	A	Neurovascular pedicle graft	11.41	NA	8.20	1.16	NA	20.77	090
15756	.....	A	Free myo/skin flap microvasc	35.23	NA	20.85	3.11	NA	59.19	090
15757	.....	A	Free skin flap, microvasc	35.23	NA	21.96	3.37	NA	60.56	090
15758	.....	A	Free fascial flap, microvasc	35.10	NA	22.00	3.52	NA	60.62	090
15760	.....	A	Composite skin graft	8.74	9.10	6.62	0.72	18.56	16.08	090
15770	.....	A	Derma-fat-fascia graft	7.52	NA	6.08	0.78	NA	14.38	090
15775	.....	R	Hair transplant punch grafts	3.96	2.87	1.35	0.43	7.26	5.74	000
15776	.....	R	Hair transplant punch grafts	5.54	5.75	2.89	0.60	11.89	9.03	000
15780	.....	A	Abrasion treatment of skin	7.29	6.61	6.58	0.41	14.31	14.28	090
15781	.....	A	Abrasion treatment of skin	4.85	5.07	4.80	0.27	10.19	9.92	090
15782	.....	A	Abrasion treatment of skin	4.32	4.30	4.15	0.21	8.83	8.68	090
15783	.....	A	Abrasion treatment of skin	4.29	4.72	3.57	0.26	9.27	8.12	090
15786	.....	A	Abrasion, lesion, single	2.03	1.77	1.29	0.11	3.91	3.43	010
15787	.....	A	Abrasion, lesions, add-on	0.33	0.32	0.16	0.02	0.67	0.51	ZZZ
15788	.....	R	Chemical peel, face, epiderm	2.09	3.14	1.03	0.11	5.34	3.23	090
15789	.....	R	Chemical peel, face, dermal	4.92	6.17	3.51	0.27	11.36	8.70	090
15792	.....	R	Chemical peel, nonfacial	1.86	2.96	2.17	0.10	4.92	4.13	090
15793	.....	A	Chemical peel, nonfacial	3.74	NA	3.50	0.17	NA	7.41	090
15810	.....	A	Salabrasion	4.74	3.73	3.73	0.42	8.89	8.89	090
15811	.....	A	Salabrasion	5.39	6.09	4.73	0.52	12.00	10.64	090
15819	.....	A	Plastic surgery, neck	9.38	NA	6.67	0.77	NA	16.82	090
15820	.....	A	Revision of lower eyelid	5.15	7.12	5.25	0.30	12.57	10.70	090
15821	.....	A	Revision of lower eyelid	5.72	7.47	5.41	0.31	13.50	11.44	090
15822	.....	A	Revision of upper eyelid	4.45	6.06	4.23	0.22	10.73	8.90	090
15823	.....	A	Revision of upper eyelid	7.05	8.06	6.13	0.32	15.43	13.50	090
15824	.....	R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825	.....	R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826	.....	R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828	.....	R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829	.....	R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15831	.....	A	Excise excessive skin tissue	12.40	NA	7.69	1.30	NA	21.39	090
15832	.....	A	Excise excessive skin tissue	11.59	NA	7.68	1.21	NA	20.48	090
15833	.....	A	Excise excessive skin tissue	10.64	NA	7.06	1.17	NA	18.87	090
15834	.....	A	Excise excessive skin tissue	10.85	NA	6.95	1.18	NA	18.98	090
15835	.....	A	Excise excessive skin tissue	11.67	NA	6.93	1.13	NA	19.73	090
15836	.....	A	Excise excessive skin tissue	9.34	NA	6.18	0.95	NA	16.47	090
15837	.....	A	Excise excessive skin tissue	8.43	7.40	6.42	0.78	16.61	15.63	090
15838	.....	A	Excise excessive skin tissue	7.13	NA	5.68	0.58	NA	13.39	090
15839	.....	A	Excise excessive skin tissue	9.38	7.21	5.75	0.88	17.47	16.01	090
15840	.....	A	Graft for face nerve palsy	13.26	NA	9.75	1.15	NA	24.16	090
15841	.....	A	Graft for face nerve palsy	23.26	NA	14.51	2.65	NA	40.42	090
15842	.....	A	Flap for face nerve palsy	37.96	NA	22.78	3.99	NA	64.73	090
15845	.....	A	Skin and muscle repair, face	12.57	NA	8.47	0.80	NA	21.84	090
15850	.....	B	Removal of sutures	+0.78	1.44	0.30	0.04	2.26	1.12	XXX
15851	.....	A	Removal of sutures	0.86	1.64	0.34	0.05	2.55	1.25	000
15852	.....	A	Dressing change,not for burn	0.86	1.75	0.36	0.07	2.68	1.29	000

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
15860	.....	A	Test for blood flow in graft	1.95	1.30	0.81	0.13	3.38	2.89	000
15876	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879	.....	R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920	.....	A	Removal of tail bone ulcer	7.95	NA	5.49	0.83	NA	14.27	090
15922	.....	A	Removal of tail bone ulcer	9.90	NA	7.31	1.06	NA	18.27	090
15931	.....	A	Remove sacrum pressure sore	9.24	NA	5.56	0.95	NA	15.75	090
15933	.....	A	Remove sacrum pressure sore	10.85	NA	7.98	1.14	NA	19.97	090
15934	.....	A	Remove sacrum pressure sore	12.69	NA	8.29	1.35	NA	22.33	090
15935	.....	A	Remove sacrum pressure sore	14.57	NA	9.96	1.56	NA	26.09	090
15936	.....	A	Remove sacrum pressure sore	12.38	NA	8.79	1.32	NA	22.49	090
15937	.....	A	Remove sacrum pressure sore	14.21	NA	10.25	1.51	NA	25.97	090
15940	.....	A	Remove hip pressure sore	9.34	NA	5.92	0.98	NA	16.24	090
15941	.....	A	Remove hip pressure sore	11.43	NA	9.80	1.23	NA	22.46	090
15944	.....	A	Remove hip pressure sore	11.46	NA	8.59	1.21	NA	21.26	090
15945	.....	A	Remove hip pressure sore	12.69	NA	9.51	1.38	NA	23.58	090
15946	.....	A	Remove hip pressure sore	21.57	NA	13.95	2.32	NA	37.84	090
15950	.....	A	Remove thigh pressure sore	7.54	NA	5.15	0.80	NA	13.49	090
15951	.....	A	Remove thigh pressure sore	10.72	NA	7.99	1.14	NA	19.85	090
15952	.....	A	Remove thigh pressure sore	11.39	NA	7.39	1.19	NA	19.97	090
15953	.....	A	Remove thigh pressure sore	12.63	NA	8.79	1.38	NA	22.80	090
15956	.....	A	Remove thigh pressure sore	15.52	NA	10.40	1.64	NA	27.56	090
15958	.....	A	Remove thigh pressure sore	15.48	NA	10.72	1.66	NA	27.86	090
15999	.....	C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000	.....	A	Initial treatment of burn(s)	0.89	1.07	0.27	0.06	2.02	1.22	000
16010	.....	A	Treatment of burn(s)	0.87	1.19	0.36	0.07	2.13	1.30	000
16015	.....	A	Treatment of burn(s)	2.35	1.89	0.94	0.22	4.46	3.51	000
16020	.....	A	Treatment of burn(s)	0.80	1.13	0.26	0.06	1.99	1.12	000
16025	.....	A	Treatment of burn(s)	1.85	1.88	0.67	0.16	3.89	2.68	000
16030	.....	A	Treatment of burn(s)	2.08	3.05	0.91	0.18	5.31	3.17	000
16035	.....	A	Incision of burn scab, initi	3.75	NA	1.50	0.36	NA	5.61	090
16036	.....	A	Incise burn scab, addl incis	1.50	NA	0.62	0.11	NA	2.23	ZZZ
17000	.....	A	Destroy benign/premlg lesion	0.60	1.04	0.27	0.03	1.67	0.90	010
17003	.....	A	Destroy lesions, 2-14	0.15	0.12	0.07	0.01	0.28	0.23	ZZZ
17004	.....	A	Destroy lesions, 15 or more	2.79	2.45	1.27	0.12	5.36	4.18	010
17106	.....	A	Destruction of skin lesions	4.59	4.77	3.21	0.28	9.64	8.08	090
17107	.....	A	Destruction of skin lesions	9.16	7.30	5.37	0.53	16.99	15.06	090
17108	.....	A	Destruction of skin lesions	13.20	9.35	7.66	0.89	23.44	21.75	090
17110	.....	A	Destruct lesion, 1-14	0.65	1.71	0.45	0.04	2.40	1.14	010
17111	.....	A	Destruct lesion, 15 or more	0.92	1.75	0.56	0.04	2.71	1.52	010
17250	.....	A	Chemical cautery, tissue	0.50	1.23	0.34	0.04	1.77	0.88	000
17260	.....	A	Destruction of skin lesions	0.91	1.37	0.41	0.04	2.32	1.36	010
17261	.....	A	Destruction of skin lesions	1.17	1.62	0.55	0.05	2.84	1.77	010
17262	.....	A	Destruction of skin lesions	1.58	1.89	0.75	0.07	3.54	2.40	010
17263	.....	A	Destruction of skin lesions	1.79	2.07	0.82	0.08	3.94	2.69	010
17264	.....	A	Destruction of skin lesions	1.94	2.25	0.86	0.08	4.27	2.88	010
17266	.....	A	Destruction of skin lesions	2.34	2.57	0.96	0.11	5.02	3.41	010
17270	.....	A	Destruction of skin lesions	1.32	1.70	0.60	0.06	3.08	1.98	010
17271	.....	A	Destruction of skin lesions	1.49	1.79	0.71	0.06	3.34	2.26	010
17272	.....	A	Destruction of skin lesions	1.77	2.00	0.85	0.07	3.84	2.69	010
17273	.....	A	Destruction of skin lesions	2.05	2.23	0.96	0.09	4.37	3.10	010
17274	.....	A	Destruction of skin lesions	2.59	2.61	1.18	0.11	5.31	3.88	010
17276	.....	A	Destruction of skin lesions	3.20	3.03	1.42	0.15	6.38	4.77	010
17280	.....	A	Destruction of skin lesions	1.17	1.61	0.53	0.05	2.83	1.75	010
17281	.....	A	Destruction of skin lesions	1.72	1.92	0.82	0.07	3.71	2.61	010
17282	.....	A	Destruction of skin lesions	2.04	2.17	0.98	0.09	4.30	3.11	010
17283	.....	A	Destruction of skin lesions	2.64	2.58	1.23	0.11	5.33	3.98	010
17284	.....	A	Destruction of skin lesions	3.21	2.99	1.49	0.14	6.34	4.84	010
17286	.....	A	Destruction of skin lesions	4.44	3.78	2.18	0.22	8.44	6.84	010
17304	.....	A	1 stage mohs, up to 5 spec	7.60	8.09	3.66	0.31	16.00	11.57	000
17305	.....	A	2 stage mohs, up to 5 spec	2.85	3.81	1.37	0.12	6.78	4.34	000
17306	.....	A	3 stage mohs, up to 5 spec	2.85	3.81	1.38	0.12	6.78	4.35	000
17307	.....	A	Mohs addl stage up to 5 spec	2.85	3.82	1.40	0.12	6.79	4.37	000
17310	.....	A	Mohs any stage > 5 spec each	0.62	1.48	0.31	0.05	2.15	0.98	ZZZ
17340	.....	A	Cryotherapy of skin	0.76	0.38	0.26	0.04	1.18	1.06	010
17360	.....	A	Skin peel therapy	1.43	1.59	0.72	0.06	3.08	2.21	010
17380	.....	R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999	.....	C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000	.....	A	Drainage of breast lesion	0.84	1.20	0.29	0.07	2.11	1.20	000
19001	.....	A	Drain breast lesion add-on	0.42	0.82	0.14	0.03	1.27	0.59	ZZZ
19020	.....	A	Incision of breast lesion	3.57	6.81	3.39	0.35	10.73	7.31	090
19030	.....	A	Injection for breast x-ray	1.53	3.56	0.52	0.07	5.16	2.12	000
19100	.....	A	Bx breast percut w/o image	1.27	1.43	0.44	0.10	2.80	1.81	000
19101	.....	A	Biopsy of breast, open	3.18	5.02	1.89	0.20	8.40	5.27	010

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
19102	.....	A	Bx breast percut w/image	2.00	4.86	0.68	0.13	6.99	2.81	000
19103	.....	A	Bx breast percut w/device	3.70	12.31	1.27	0.16	16.17	5.13	000
19110	.....	A	Nipple exploration	4.30	8.62	4.43	0.44	13.36	9.17	090
19112	.....	A	Excise breast duct fistula	3.67	9.15	3.08	0.38	13.20	7.13	090
19120	.....	A	Removal of breast lesion	5.56	4.92	3.09	0.56	11.04	9.21	090
19125	.....	A	Excision, breast lesion	6.06	5.05	3.26	0.61	11.72	9.93	090
19126	.....	A	Excision, addl breast lesion	2.93	NA	1.02	0.30	NA	4.25	ZZZ
19140	.....	A	Removal of breast tissue	5.14	9.35	3.65	0.52	15.01	9.31	090
19160	.....	A	Removal of breast tissue	5.99	NA	4.52	0.61	NA	11.12	090
19162	.....	A	Remove breast tissue, nodes	13.53	NA	7.88	1.38	NA	22.79	090
19180	.....	A	Removal of breast	8.80	NA	5.93	0.88	NA	15.61	090
19182	.....	A	Removal of breast	7.73	NA	4.98	0.79	NA	13.50	090
19200	.....	A	Removal of breast	15.49	NA	9.07	1.51	NA	26.07	090
19220	.....	A	Removal of breast	15.72	NA	9.12	1.56	NA	26.40	090
19240	.....	A	Removal of breast	16.00	NA	8.74	1.62	NA	26.36	090
19260	.....	A	Removal of chest wall lesion	15.44	NA	9.13	1.64	NA	26.21	090
19271	.....	A	Revision of chest wall	18.90	NA	11.31	2.27	NA	32.48	090
19272	.....	A	Extensive chest wall surgery	21.55	NA	12.24	2.54	NA	36.33	090
19290	.....	A	Place needle wire, breast	1.27	2.89	0.43	0.06	4.22	1.76	000
19291	.....	A	Place needle wire, breast	0.63	1.69	0.21	0.03	2.35	0.87	ZZZ
19295	.....	A	Place breast clip, percut	0.00	2.65	NA	0.01	2.66	NA	ZZZ
19316	.....	A	Suspension of breast	10.69	NA	7.57	1.15	NA	19.41	090
19318	.....	A	Reduction of large breast	15.62	NA	11.72	1.69	NA	29.03	090
19324	.....	A	Enlarge breast	5.85	NA	4.25	0.63	NA	10.73	090
19325	.....	A	Enlarge breast with implant	8.45	NA	6.25	0.90	NA	15.60	090
19328	.....	A	Removal of breast implant	5.68	NA	4.54	0.61	NA	10.83	090
19330	.....	A	Removal of implant material	7.59	NA	5.20	0.81	NA	13.60	090
19340	.....	A	Immediate breast prosthesis	6.33	NA	3.19	0.68	NA	10.20	ZZZ
19342	.....	A	Delayed breast prosthesis	11.20	NA	7.83	1.21	NA	20.24	090
19350	.....	A	Breast reconstruction	8.92	13.45	6.80	0.95	23.32	16.67	090
19355	.....	A	Correct inverted nipple(s)	7.57	13.63	5.41	0.80	22.00	13.78	090
19357	.....	A	Breast reconstruction	18.16	NA	9.82	1.96	NA	29.94	090
19361	.....	A	Breast reconstruction	19.26	NA	10.27	2.08	NA	31.61	090
19364	.....	A	Breast reconstruction	41.00	NA	25.22	3.91	NA	70.13	090
19366	.....	A	Breast reconstruction	21.28	NA	10.27	2.27	NA	33.82	090
19367	.....	A	Breast reconstruction	25.73	NA	17.47	2.78	NA	45.98	090
19368	.....	A	Breast reconstruction	32.42	NA	21.08	3.51	NA	57.01	090
19369	.....	A	Breast reconstruction	29.82	NA	20.65	3.24	NA	53.71	090
19370	.....	A	Surgery of breast capsule	8.05	NA	6.08	0.86	NA	14.99	090
19371	.....	A	Removal of breast capsule	9.35	NA	7.15	1.01	NA	17.51	090
19380	.....	A	Revise breast reconstruction	9.14	NA	7.05	0.98	NA	17.17	090
19396	.....	A	Design custom breast implant	2.17	6.25	1.02	0.23	8.65	3.42	000
19499	.....	C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000	.....	A	Incision of abscess	2.12	2.16	1.18	0.17	4.45	3.47	010
20005	.....	A	Incision of deep abscess	3.42	3.03	2.21	0.34	6.79	5.97	010
20100	.....	A	Explore wound, neck	10.08	5.82	4.37	0.99	16.89	15.44	010
20101	.....	A	Explore wound, chest	3.22	2.90	1.50	0.24	6.36	4.96	010
20102	.....	A	Explore wound, abdomen	3.94	3.39	1.75	0.35	7.68	6.04	010
20103	.....	A	Explore wound, extremity	5.30	4.26	3.02	0.57	10.13	8.89	010
20150	.....	A	Excise epiphyseal bar	13.69	NA	8.96	0.96	NA	23.61	090
20200	.....	A	Muscle biopsy	1.46	1.70	0.61	0.17	3.33	2.24	000
20205	.....	A	Deep muscle biopsy	2.35	3.87	0.96	0.23	6.45	3.54	000
20206	.....	A	Needle biopsy, muscle	0.99	3.15	0.35	0.06	4.20	1.40	000
20220	.....	A	Bone biopsy, trocar/needle	1.27	4.87	2.93	0.06	6.20	4.26	000
20225	.....	A	Bone biopsy, trocar/needle	1.87	4.37	3.02	0.11	6.35	5.00	000
20240	.....	A	Bone biopsy, excisional	3.23	NA	4.22	0.33	NA	7.78	010
20245	.....	A	Bone biopsy, excisional	7.78	NA	6.91	0.44	NA	15.13	010
20250	.....	A	Open bone biopsy	5.03	NA	4.37	0.50	NA	9.90	010
20251	.....	A	Open bone biopsy	5.56	NA	4.92	0.79	NA	11.27	010
20500	.....	A	Injection of sinus tract	1.23	5.89	3.82	0.10	7.22	5.15	010
20501	.....	A	Inject sinus tract for x-ray	0.76	3.14	0.26	0.03	3.93	1.05	000
20520	.....	A	Removal of foreign body	1.85	5.60	3.59	0.17	7.62	5.61	010
20525	.....	A	Removal of foreign body	3.50	6.84	4.38	0.40	10.74	8.28	010
20526	.....	A	Ther injection, carp tunnel	0.94	0.77	0.41	0.06	1.77	1.41	000
20550	.....	A	Inj tendon sheath/ligament	0.75	0.76	0.24	0.06	1.57	1.05	000
20551	.....	A	Inject tendon origin/insert	0.75	0.70	0.34	0.06	1.51	1.15	000
20552	.....	A	Inject trigger point, 1 or 2	0.66	0.66	0.30	0.06	1.38	1.02	000
20553	.....	A	Inject trigger points, =/> 3	0.75	0.75	0.34	0.06	1.56	1.15	000
20600	.....	A	Drain/inject, joint/bursa	0.66	0.66	0.36	0.06	1.38	1.08	000
20605	.....	A	Drain/inject, joint/bursa	0.68	0.78	0.37	0.06	1.52	1.11	000
20610	.....	A	Drain/inject, joint/bursa	0.79	0.97	0.42	0.08	1.84	1.29	000
20612	.....	A	Aspirate/inj ganglion cyst	0.70	0.77	0.28	0.06	1.53	1.04	000
20615	.....	A	Treatment of bone cyst	2.28	4.87	2.69	0.19	7.34	5.16	010
20650	.....	A	Insert and remove bone pin	2.23	5.08	3.29	0.28	7.59	5.80	010
20660	.....	A	Apply, rem fixation device	2.51	NA	2.28	0.48	NA	5.27	000

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
20661	.....	A	Application of head brace	4.89	NA	6.91	0.92	NA	12.72	090
20662	.....	A	Application of pelvis brace	6.07	NA	6.27	0.81	NA	13.15	090
20663	.....	A	Application of thigh brace	5.43	NA	5.58	0.77	NA	11.78	090
20664	.....	A	Halo brace application	8.06	NA	8.62	1.49	NA	18.17	090
20665	.....	A	Removal of fixation device	1.31	2.14	1.30	0.17	3.62	2.78	010
20670	.....	A	Removal of support implant	1.74	6.09	3.55	0.23	8.06	5.52	010
20680	.....	A	Removal of support implant	3.35	5.37	5.37	0.46	9.18	9.18	090
20690	.....	A	Apply bone fixation device	3.52	NA	1.82	0.47	NA	5.81	090
20692	.....	A	Apply bone fixation device	6.41	NA	3.05	0.60	NA	10.06	090
20693	.....	A	Adjust bone fixation device	5.86	NA	13.20	0.85	NA	19.91	090
20694	.....	A	Remove bone fixation device	4.16	9.45	6.56	0.57	14.18	11.29	090
20802	.....	A	Replantation, arm, complete	41.15	NA	27.57	5.81	NA	74.53	090
20805	.....	A	Replant forearm, complete	50.00	NA	43.16	3.95	NA	97.11	090
20808	.....	A	Replantation hand, complete	61.65	NA	49.60	6.49	NA	117.74	090
20816	.....	A	Replantation digit, complete	30.94	NA	46.54	3.01	NA	80.49	090
20822	.....	A	Replantation digit, complete	25.59	NA	42.54	3.07	NA	71.20	090
20824	.....	A	Replantation thumb, complete	30.94	NA	45.41	3.48	NA	79.83	090
20827	.....	A	Replantation thumb, complete	26.41	NA	45.08	3.21	NA	74.70	090
20838	.....	A	Replantation foot, complete	41.41	NA	28.58	5.85	NA	75.84	090
20900	.....	A	Removal of bone for graft	5.58	6.60	6.39	0.77	12.95	12.74	090
20902	.....	A	Removal of bone for graft	7.55	NA	9.17	1.06	NA	17.78	090
20910	.....	A	Remove cartilage for graft	5.34	8.85	6.69	0.50	14.69	12.53	090
20912	.....	A	Remove cartilage for graft	6.35	NA	7.49	0.55	NA	14.39	090
20920	.....	A	Removal of fascia for graft	5.31	NA	5.57	0.54	NA	11.42	090
20922	.....	A	Removal of fascia for graft	6.61	8.97	6.40	0.88	16.46	13.89	090
20924	.....	A	Removal of tendon for graft	6.48	NA	7.16	0.82	NA	14.46	090
20926	.....	A	Removal of tissue for graft	5.53	NA	6.42	0.73	NA	12.68	090
20930	.....	B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931	.....	A	Spinal bone allograft	1.81	NA	0.96	0.34	NA	3.11	ZZZ
20936	.....	B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937	.....	A	Spinal bone autograft	2.79	NA	1.49	0.43	NA	4.71	ZZZ
20938	.....	A	Spinal bone autograft	3.02	NA	1.59	0.52	NA	5.13	ZZZ
20950	.....	A	Fluid pressure, muscle	1.26	NA	2.24	0.16	NA	3.66	000
20955	.....	A	Fibula bone graft, microvasc	39.21	NA	29.76	4.35	NA	73.32	090
20956	.....	A	Iliac bone graft, microvasc	39.27	NA	28.79	5.77	NA	73.83	090
20957	.....	A	Mt bone graft, microvasc	40.65	NA	21.19	5.74	NA	67.58	090
20962	.....	A	Other bone graft, microvasc	39.27	NA	28.28	5.19	NA	72.74	090
20969	.....	A	Bone/skin graft, microvasc	43.92	NA	32.14	4.34	NA	80.40	090
20970	.....	A	Bone/skin graft, iliac crest	43.06	NA	30.05	4.64	NA	77.75	090
20972	.....	A	Bone/skin graft, metatarsal	42.99	NA	18.39	6.07	NA	67.45	090
20973	.....	A	Bone/skin graft, great toe	45.76	NA	28.24	4.65	NA	78.65	090
20974	.....	A	Electrical bone stimulation	0.62	0.42	0.33	0.09	1.13	1.04	000
20975	.....	A	Electrical bone stimulation	2.60	NA	1.38	0.42	NA	4.40	000
20979	.....	A	Us bone stimulation	0.62	0.73	0.35	0.04	1.39	1.01	000
20999	.....	C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010	.....	A	Incision of jaw joint	10.14	NA	7.16	0.54	NA	17.84	090
21015	.....	A	Resection of facial tumor	5.29	NA	7.09	0.52	NA	12.90	090
21025	.....	A	Excision of bone, lower jaw	10.06	7.35	6.87	0.79	18.20	17.72	090
21026	.....	A	Excision of facial bone(s)	4.85	5.39	5.08	0.40	10.64	10.33	090
21029	.....	A	Contour of face bone lesion	7.71	6.96	6.15	0.74	15.41	14.60	090
21030	.....	A	Excise max/zygoma b9 tumor	3.89	4.36	3.64	0.60	8.85	8.13	090
21031	.....	A	Remove exostosis, mandible	3.24	3.35	2.17	0.28	6.87	5.69	090
21032	.....	A	Remove exostosis, maxilla	3.24	3.32	2.29	0.27	6.83	5.80	090
21034	.....	A	Excise max/zygoma mlg tumor	16.17	10.67	10.64	1.37	28.21	28.18	090
21040	.....	A	Excise mandible lesion	3.89	3.76	2.58	0.19	7.84	6.66	090
21041	.....	D	Removal of jaw bone lesion	0.00	0.00	0.00	0.00	0.00	0.00	090
21044	.....	A	Removal of jaw bone lesion	11.86	NA	7.96	0.87	NA	20.69	090
21045	.....	A	Extensive jaw surgery	16.17	NA	10.29	1.20	NA	27.66	090
21046	.....	A	Remove mandible cyst complex	13.00	NA	10.42	1.01	NA	24.43	090
21047	.....	A	Excise lwr jaw cyst w/repair	18.75	NA	9.87	1.53	NA	30.15	090
21048	.....	A	Remove maxilla cyst complex	13.50	NA	10.63	1.01	NA	25.14	090
21049	.....	A	Excis uppr jaw cyst w/repair	18.00	NA	9.55	1.01	NA	28.56	090
21050	.....	A	Removal of jaw joint	10.77	NA	11.63	0.84	NA	23.24	090
21060	.....	A	Remove jaw joint cartilage	10.23	NA	10.09	1.16	NA	21.48	090
21070	.....	A	Remove coronoid process	8.20	NA	5.98	0.67	NA	14.85	090
21076	.....	A	Prepare face/oral prosthesis	13.42	9.49	7.13	1.36	24.27	21.91	010
21077	.....	A	Prepare face/oral prosthesis	33.75	23.88	17.94	3.43	61.06	55.12	090
21079	.....	A	Prepare face/oral prosthesis	22.34	16.88	12.41	1.59	40.81	36.34	090
21080	.....	A	Prepare face/oral prosthesis	25.10	18.97	13.94	2.55	46.62	41.59	090
21081	.....	A	Prepare face/oral prosthesis	22.88	17.28	12.71	1.87	42.03	37.46	090
21082	.....	A	Prepare face/oral prosthesis	20.87	14.77	11.10	1.46	37.10	33.43	090
21083	.....	A	Prepare face/oral prosthesis	19.30	14.58	10.72	1.96	35.84	31.98	090
21084	.....	A	Prepare face/oral prosthesis	22.51	17.01	12.51	1.57	41.09	36.59	090
21085	.....	A	Prepare face/oral prosthesis	9.00	6.37	4.79	0.65	16.02	14.44	010
21086	.....	A	Prepare face/oral prosthesis	24.92	18.83	13.84	1.86	45.61	40.62	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
21087	.....	A	Prepare face/oral prosthesis	24.92	17.63	13.24	2.22	44.77	40.38	090
21088	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089	.....	C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100	.....	A	Maxillofacial fixation	4.22	5.93	4.05	0.18	10.33	8.45	090
21110	.....	A	Interdental fixation	5.21	5.31	4.32	0.28	10.80	9.81	090
21116	.....	A	Injection, jaw joint x-ray	0.81	7.71	0.29	0.05	8.57	1.15	000
21120	.....	A	Reconstruction of chin	4.93	9.80	6.08	0.29	15.02	11.30	090
21121	.....	A	Reconstruction of chin	7.64	7.94	6.21	0.56	16.14	14.41	090
21122	.....	A	Reconstruction of chin	8.52	NA	7.63	0.59	NA	16.74	090
21123	.....	A	Reconstruction of chin	11.16	NA	8.08	1.16	NA	20.40	090
21125	.....	A	Augmentation, lower jaw bone	10.62	9.53	8.07	0.72	20.87	19.41	090
21127	.....	A	Augmentation, lower jaw bone	11.12	9.80	7.50	0.76	21.68	19.38	090
21137	.....	A	Reduction of forehead	9.82	NA	8.03	0.53	NA	18.38	090
21138	.....	A	Reduction of forehead	12.19	NA	9.40	1.47	NA	23.06	090
21139	.....	A	Reduction of forehead	14.61	NA	9.78	1.02	NA	25.41	090
21141	.....	A	Reconstruct midface, lefort	18.10	NA	10.79	1.63	NA	30.52	090
21142	.....	A	Reconstruct midface, lefort	18.81	NA	12.16	1.16	NA	32.13	090
21143	.....	A	Reconstruct midface, lefort	19.58	NA	11.10	0.90	NA	31.58	090
21145	.....	A	Reconstruct midface, lefort	19.94	NA	11.25	2.09	NA	33.28	090
21146	.....	A	Reconstruct midface, lefort	20.71	NA	11.92	2.13	NA	34.76	090
21147	.....	A	Reconstruct midface, lefort	21.77	NA	12.15	1.52	NA	35.44	090
21150	.....	A	Reconstruct midface, lefort	25.24	NA	16.33	1.09	NA	42.66	090
21151	.....	A	Reconstruct midface, lefort	28.30	NA	19.93	1.98	NA	50.21	090
21154	.....	A	Reconstruct midface, lefort	30.52	NA	19.84	4.86	NA	55.22	090
21155	.....	A	Reconstruct midface, lefort	34.45	NA	20.75	5.48	NA	60.68	090
21159	.....	A	Reconstruct midface, lefort	42.38	NA	25.58	6.74	NA	74.70	090
21160	.....	A	Reconstruct midface, lefort	46.44	NA	26.69	4.39	NA	77.52	090
21172	.....	A	Reconstruct orbit/forehead	27.80	NA	15.82	1.91	NA	45.53	090
21175	.....	A	Reconstruct orbit/forehead	33.17	NA	20.06	5.16	NA	58.39	090
21179	.....	A	Reconstruct entire forehead	22.25	NA	17.84	2.48	NA	42.57	090
21180	.....	A	Reconstruct entire forehead	25.19	NA	18.59	2.15	NA	45.93	090
21181	.....	A	Contour cranial bone lesion	9.90	NA	8.34	0.97	NA	19.21	090
21182	.....	A	Reconstruct cranial bone	32.19	NA	21.89	2.53	NA	56.61	090
21183	.....	A	Reconstruct cranial bone	35.31	NA	23.87	2.75	NA	61.93	090
21184	.....	A	Reconstruct cranial bone	38.24	NA	24.30	4.12	NA	66.66	090
21188	.....	A	Reconstruction of midface	22.46	NA	15.62	1.85	NA	39.93	090
21193	.....	A	Reconst lwr jaw w/o graft	17.15	NA	10.78	1.53	NA	29.46	090
21194	.....	A	Reconst lwr jaw w/graft	19.84	NA	12.72	1.39	NA	33.95	090
21195	.....	A	Reconst lwr jaw w/o fixation	17.24	NA	12.35	1.20	NA	30.79	090
21196	.....	A	Reconst lwr jaw w/fixation	18.91	NA	12.91	1.62	NA	33.44	090
21198	.....	A	Reconstr lwr jaw segment	14.16	NA	11.66	1.05	NA	26.87	090
21199	.....	A	Reconstr lwr jaw w/advance	16.00	NA	9.29	1.26	NA	26.55	090
21206	.....	A	Reconstruct upper jaw bone	14.10	NA	9.72	1.01	NA	24.83	090
21208	.....	A	Augmentation of facial bones	10.23	9.69	8.36	0.92	20.84	19.51	090
21209	.....	A	Reduction of facial bones	6.72	7.97	5.79	0.60	15.29	13.11	090
21210	.....	A	Face bone graft	10.23	8.99	8.14	0.88	20.10	19.25	090
21215	.....	A	Lower jaw bone graft	10.77	8.90	7.08	1.04	20.71	18.89	090
21230	.....	A	Rib cartilage graft	10.77	NA	10.06	0.96	NA	21.79	090
21235	.....	A	Ear cartilage graft	6.72	12.21	8.03	0.52	19.45	15.27	090
21240	.....	A	Reconstruction of jaw joint	14.05	NA	11.30	1.15	NA	26.50	090
21242	.....	A	Reconstruction of jaw joint	12.95	NA	11.07	1.40	NA	25.42	090
21243	.....	A	Reconstruction of jaw joint	20.79	NA	13.76	1.85	NA	36.40	090
21244	.....	A	Reconstruction of lower jaw	11.86	NA	9.17	0.95	NA	21.98	090
21245	.....	A	Reconstruction of jaw	11.86	12.18	10.18	0.88	24.92	22.92	090
21246	.....	A	Reconstruction of jaw	12.47	10.33	10.33	1.21	24.01	24.01	090
21247	.....	A	Reconstruct lower jaw bone	22.63	NA	16.39	2.21	NA	41.23	090
21248	.....	A	Reconstruction of jaw	11.48	8.99	7.76	1.01	21.48	20.25	090
21249	.....	A	Reconstruction of jaw	17.52	11.51	10.20	1.39	30.42	29.11	090
21255	.....	A	Reconstruct lower jaw bone	16.72	NA	11.44	1.13	NA	29.29	090
21256	.....	A	Reconstruction of orbit	16.19	NA	13.27	1.04	NA	30.50	090
21260	.....	A	Revise eye sockets	16.52	NA	10.71	1.25	NA	28.48	090
21261	.....	A	Revise eye sockets	31.49	NA	20.59	2.20	NA	54.28	090
21263	.....	A	Revise eye sockets	28.42	NA	12.98	2.16	NA	43.56	090
21267	.....	A	Revise eye sockets	18.90	NA	14.48	1.35	NA	34.73	090
21268	.....	A	Revise eye sockets	24.48	NA	16.12	0.79	NA	41.39	090
21270	.....	A	Augmentation, cheek bone	10.23	9.54	9.54	0.73	20.50	20.50	090
21275	.....	A	Revision, orbitofacial bones	11.24	NA	10.78	1.03	NA	23.05	090
21280	.....	A	Revision of eyelid	6.03	NA	6.07	0.27	NA	12.37	090
21282	.....	A	Revision of eyelid	3.49	NA	5.15	0.21	NA	8.85	090
21295	.....	A	Revision of jaw muscle/bone	1.53	NA	4.35	0.13	NA	6.01	090
21296	.....	A	Revision of jaw muscle/bone	4.25	NA	4.55	0.30	NA	9.10	090
21299	.....	C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300	.....	A	Treatment of skull fracture	0.72	2.73	0.26	0.09	3.54	1.07	000
21310	.....	A	Treatment of nose fracture	0.58	2.68	0.15	0.05	3.31	0.78	000
21315	.....	A	Treatment of nose fracture	1.51	3.43	1.27	0.12	5.06	2.90	010

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
21320	.....	A	Treatment of nose fracture	1.85	4.83	2.03	0.15	6.83	4.03	010
21325	.....	A	Treatment of nose fracture	3.77	NA	3.67	0.31	NA	7.75	090
21330	.....	A	Treatment of nose fracture	5.38	NA	5.51	0.48	NA	11.37	090
21335	.....	A	Treatment of nose fracture	8.61	NA	7.16	0.64	NA	16.41	090
21336	.....	A	Treat nasal septal fracture	5.72	NA	5.55	0.45	NA	11.72	090
21337	.....	A	Treat nasal septal fracture	2.70	5.23	3.25	0.22	8.15	6.17	090
21338	.....	A	Treat nasoethmoid fracture	6.46	NA	5.96	0.53	NA	12.95	090
21339	.....	A	Treat nasoethmoid fracture	8.09	NA	6.70	0.76	NA	15.55	090
21340	.....	A	Treatment of nose fracture	10.77	NA	9.09	0.85	NA	20.71	090
21343	.....	A	Treatment of sinus fracture	12.95	NA	9.77	1.06	NA	23.78	090
21344	.....	A	Treatment of sinus fracture	19.72	NA	13.44	1.72	NA	34.88	090
21345	.....	A	Treat nose/jaw fracture	8.16	9.73	7.91	0.60	18.49	16.67	090
21346	.....	A	Treat nose/jaw fracture	10.61	NA	10.05	0.85	NA	21.51	090
21347	.....	A	Treat nose/jaw fracture	12.69	NA	9.50	1.14	NA	23.33	090
21348	.....	A	Treat nose/jaw fracture	16.69	NA	10.93	1.50	NA	29.12	090
21355	.....	A	Treat cheek bone fracture	3.77	4.40	2.28	0.29	8.46	6.34	010
21356	.....	A	Treat cheek bone fracture	4.15	NA	3.23	0.36	NA	7.74	010
21360	.....	A	Treat cheek bone fracture	6.46	NA	5.63	0.52	NA	12.61	090
21365	.....	A	Treat cheek bone fracture	14.95	NA	11.31	1.30	NA	27.56	090
21366	.....	A	Treat cheek bone fracture	17.77	NA	11.90	1.41	NA	31.08	090
21385	.....	A	Treat eye socket fracture	9.16	NA	7.53	0.64	NA	17.33	090
21386	.....	A	Treat eye socket fracture	9.16	NA	7.97	0.76	NA	17.89	090
21387	.....	A	Treat eye socket fracture	9.70	NA	8.22	0.78	NA	18.70	090
21390	.....	A	Treat eye socket fracture	10.13	NA	8.47	0.70	NA	19.30	090
21395	.....	A	Treat eye socket fracture	12.68	NA	9.79	1.09	NA	23.56	090
21400	.....	A	Treat eye socket fracture	1.40	3.12	1.05	0.12	4.64	2.57	090
21401	.....	A	Treat eye socket fracture	3.26	4.83	3.11	0.34	8.43	6.71	090
21406	.....	A	Treat eye socket fracture	7.01	NA	6.75	0.59	NA	14.35	090
21407	.....	A	Treat eye socket fracture	8.61	NA	7.75	0.67	NA	17.03	090
21408	.....	A	Treat eye socket fracture	12.38	NA	10.01	1.24	NA	23.63	090
21421	.....	A	Treat mouth roof fracture	5.14	7.44	6.09	0.42	13.00	11.65	090
21422	.....	A	Treat mouth roof fracture	8.32	NA	7.49	0.69	NA	16.50	090
21423	.....	A	Treat mouth roof fracture	10.40	NA	8.02	0.95	NA	19.37	090
21431	.....	A	Treat craniofacial fracture	7.05	NA	6.68	0.58	NA	14.31	090
21432	.....	A	Treat craniofacial fracture	8.61	NA	7.74	0.55	NA	16.90	090
21433	.....	A	Treat craniofacial fracture	25.35	NA	17.10	2.46	NA	44.91	090
21435	.....	A	Treat craniofacial fracture	17.25	NA	12.56	1.66	NA	31.47	090
21436	.....	A	Treat craniofacial fracture	28.04	NA	17.16	2.32	NA	47.52	090
21440	.....	A	Treat dental ridge fracture	2.70	5.68	3.64	0.22	8.60	6.56	090
21445	.....	A	Treat dental ridge fracture	5.38	7.04	5.17	0.55	12.97	11.10	090
21450	.....	A	Treat lower jaw fracture	2.97	6.87	2.74	0.23	10.07	5.94	090
21451	.....	A	Treat lower jaw fracture	4.87	6.63	5.65	0.39	11.89	10.91	090
21452	.....	A	Treat lower jaw fracture	1.98	9.39	4.20	0.14	11.51	6.32	090
21453	.....	A	Treat lower jaw fracture	5.54	7.52	6.40	0.49	13.55	12.43	090
21454	.....	A	Treat lower jaw fracture	6.46	NA	5.78	0.55	NA	12.79	090
21461	.....	A	Treat lower jaw fracture	8.09	9.26	7.94	0.73	18.08	16.76	090
21462	.....	A	Treat lower jaw fracture	9.79	10.56	8.08	0.80	21.15	18.67	090
21465	.....	A	Treat lower jaw fracture	11.91	NA	7.87	0.84	NA	20.62	090
21470	.....	A	Treat lower jaw fracture	15.34	NA	9.93	1.36	NA	26.63	090
21480	.....	A	Reset dislocated jaw	0.61	1.58	0.18	0.05	2.24	0.84	000
21485	.....	A	Reset dislocated jaw	3.99	3.85	3.39	0.31	8.15	7.69	090
21490	.....	A	Repair dislocated jaw	11.86	NA	7.57	1.31	NA	20.74	090
21493	.....	A	Treat hyoid bone fracture	1.27	NA	3.38	0.10	NA	4.75	090
21494	.....	A	Treat hyoid bone fracture	6.28	NA	5.06	0.44	NA	11.78	090
21495	.....	A	Treat hyoid bone fracture	5.69	NA	5.00	0.41	NA	11.10	090
21497	.....	A	Interdental wiring	3.86	4.75	3.97	0.31	8.92	8.14	090
21499	.....	C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501	.....	A	Drain neck/chest lesion	3.81	4.39	3.59	0.36	8.56	7.76	090
21502	.....	A	Drain chest lesion	7.12	NA	7.44	0.79	NA	15.35	090
21510	.....	A	Drainage of bone lesion	5.74	NA	7.16	0.67	NA	13.57	090
21550	.....	A	Biopsy of neck/chest	2.06	2.33	1.22	0.13	4.52	3.41	010
21555	.....	A	Remove lesion, neck/chest	4.35	4.26	2.44	0.41	9.02	7.20	090
21556	.....	A	Remove lesion, neck/chest	5.57	NA	3.21	0.51	NA	9.29	090
21557	.....	A	Remove tumor, neck/chest	8.88	NA	7.68	0.85	NA	17.41	090
21600	.....	A	Partial removal of rib	6.89	NA	7.57	0.81	NA	15.27	090
21610	.....	A	Partial removal of rib	14.61	NA	11.24	1.85	NA	27.70	090
21615	.....	A	Removal of rib	9.87	NA	8.07	1.20	NA	19.14	090
21616	.....	A	Removal of rib and nerves	12.04	NA	9.27	1.31	NA	22.62	090
21620	.....	A	Partial removal of sternum	6.79	NA	8.04	0.77	NA	15.60	090
21627	.....	A	Sternal debridement	6.81	NA	12.58	0.82	NA	20.21	090
21630	.....	A	Extensive sternum surgery	17.38	NA	13.52	1.95	NA	32.85	090
21632	.....	A	Extensive sternum surgery	18.14	NA	12.17	2.16	NA	32.47	090
21700	.....	A	Revision of neck muscle	6.19	9.22	7.25	0.31	15.72	13.75	090
21705	.....	A	Revision of neck muscle/rib	9.60	NA	7.62	0.92	NA	18.14	090
21720	.....	A	Revision of neck muscle	5.68	7.95	7.01	0.80	14.43	13.49	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
21725	.....	A	Revision of neck muscle	6.99	NA	7.45	0.90	NA	15.34	090
21740	.....	A	Reconstruction of sternum	16.50	NA	12.48	2.03	NA	31.01	090
21742	.....	C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743	.....	C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750	.....	A	Repair of sternum separation	10.77	NA	9.85	1.35	NA	21.97	090
21800	.....	A	Treatment of rib fracture	0.96	2.38	1.08	0.09	3.43	2.13	090
21805	.....	A	Treatment of rib fracture	2.75	NA	4.71	0.29	NA	7.75	090
21810	.....	A	Treatment of rib fracture(s)	6.86	NA	7.06	0.60	NA	14.52	090
21820	.....	A	Treat sternum fracture	1.28	2.92	1.56	0.15	4.35	2.99	090
21825	.....	A	Treat sternum fracture	7.41	NA	10.26	0.84	NA	18.51	090
21899	.....	C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920	.....	A	Biopsy soft tissue of back	2.06	2.45	0.75	0.12	4.63	2.93	010
21925	.....	A	Biopsy soft tissue of back	4.49	11.93	4.68	0.44	16.86	9.61	090
21930	.....	A	Remove lesion, back or flank	5.00	4.60	2.62	0.49	10.09	8.11	090
21935	.....	A	Remove tumor, back	17.96	NA	13.01	1.87	NA	32.84	090
22100	.....	A	Remove part of neck vertebra	9.73	NA	8.38	1.55	NA	19.66	090
22101	.....	A	Remove part, thorax vertebra	9.81	NA	8.57	1.51	NA	19.89	090
22102	.....	A	Remove part, lumbar vertebra	9.81	NA	8.77	1.46	NA	20.04	090
22103	.....	A	Remove extra spine segment	2.34	NA	1.24	0.37	NA	3.95	ZZZ
22110	.....	A	Remove part of neck vertebra	12.74	NA	10.66	2.20	NA	25.60	090
22112	.....	A	Remove part, thorax vertebra	12.81	NA	10.54	1.96	NA	25.31	090
22114	.....	A	Remove part, lumbar vertebra	12.81	NA	10.45	1.98	NA	25.24	090
22116	.....	A	Remove extra spine segment	2.32	NA	1.19	0.40	NA	3.91	ZZZ
22210	.....	A	Revision of neck spine	23.82	NA	17.10	4.23	NA	45.15	090
22212	.....	A	Revision of thorax spine	19.42	NA	14.61	2.78	NA	36.81	090
22214	.....	A	Revision of lumbar spine	19.45	NA	15.09	2.78	NA	37.32	090
22216	.....	A	Revise, extra spine segment	6.04	NA	3.21	0.98	NA	10.23	ZZZ
22220	.....	A	Revision of neck spine	21.37	NA	15.50	3.65	NA	40.52	090
22222	.....	A	Revision of thorax spine	21.52	NA	13.08	3.08	NA	37.68	090
22224	.....	A	Revision of lumbar spine	21.52	NA	15.72	3.20	NA	40.44	090
22226	.....	A	Revise, extra spine segment	6.04	NA	3.17	1.01	NA	10.22	ZZZ
22305	.....	A	Treat spine process fracture	2.05	3.40	2.82	0.29	5.74	5.16	090
22310	.....	A	Treat spine fracture	2.61	5.04	4.44	0.37	8.02	7.42	090
22315	.....	A	Treat spine fracture	8.84	NA	8.64	1.37	NA	18.85	090
22318	.....	A	Treat odontoid fx w/o graft	21.50	NA	14.63	4.26	NA	40.39	090
22319	.....	A	Treat odontoid fx w/graft	24.00	NA	17.14	4.76	NA	45.90	090
22325	.....	A	Treat spine fracture	18.30	NA	13.88	2.61	NA	34.79	090
22326	.....	A	Treat neck spine fracture	19.59	NA	15.00	3.54	NA	38.13	090
22327	.....	A	Treat thorax spine fracture	19.20	NA	14.24	2.75	NA	36.19	090
22328	.....	A	Treat each add spine fx	4.61	NA	2.33	0.66	NA	7.60	ZZZ
22505	.....	A	Manipulation of spine	1.87	4.80	3.19	0.27	6.94	5.33	010
22520	.....	A	Percut vertebroplasty thor	8.91	NA	3.98	0.99	NA	13.88	010
22521	.....	A	Percut vertebroplasty lumb	8.34	NA	3.81	0.93	NA	13.08	010
22522	.....	A	Percut vertebroplasty addl	4.31	NA	1.73	0.33	NA	6.37	ZZZ
22548	.....	A	Neck spine fusion	25.82	NA	16.22	4.98	NA	47.02	090
22554	.....	A	Neck spine fusion	18.62	NA	12.63	3.51	NA	34.76	090
22556	.....	A	Thorax spine fusion	23.46	NA	14.89	3.78	NA	42.13	090
22558	.....	A	Lumbar spine fusion	22.28	NA	13.40	3.18	NA	38.86	090
22585	.....	A	Additional spinal fusion	5.53	NA	2.87	0.98	NA	9.38	ZZZ
22590	.....	A	Spine & skull spinal fusion	20.51	NA	13.62	3.81	NA	37.94	090
22595	.....	A	Neck spinal fusion	19.39	NA	13.12	3.62	NA	36.13	090
22600	.....	A	Neck spine fusion	16.14	NA	11.40	2.89	NA	30.43	090
22610	.....	A	Thorax spine fusion	16.02	NA	11.56	2.66	NA	30.24	090
22612	.....	A	Lumbar spine fusion	21.00	NA	14.36	3.28	NA	38.64	090
22614	.....	A	Spine fusion, extra segment	6.44	NA	3.44	1.04	NA	10.92	ZZZ
22630	.....	A	Lumbar spine fusion	20.84	NA	14.01	3.79	NA	38.64	090
22632	.....	A	Spine fusion, extra segment	5.23	NA	2.74	0.90	NA	8.87	ZZZ
22800	.....	A	Fusion of spine	18.25	NA	13.02	2.71	NA	33.98	090
22802	.....	A	Fusion of spine	30.88	NA	19.99	4.42	NA	55.29	090
22804	.....	A	Fusion of spine	36.27	NA	23.15	5.23	NA	64.65	090
22808	.....	A	Fusion of spine	26.27	NA	16.72	4.36	NA	47.35	090
22810	.....	A	Fusion of spine	30.27	NA	18.75	4.49	NA	53.51	090
22812	.....	A	Fusion of spine	32.70	NA	20.27	4.67	NA	57.64	090
22818	.....	A	Kyphectomy, 1-2 segments	31.83	NA	19.49	5.01	NA	56.33	090
22819	.....	A	Kyphectomy, 3 or more	36.44	NA	20.58	5.20	NA	62.22	090
22830	.....	A	Exploration of spinal fusion	10.85	NA	8.32	1.73	NA	20.90	090
22840	.....	A	Insert spine fixation device	12.54	NA	6.67	2.03	NA	21.24	ZZZ
22841	.....	B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842	.....	A	Insert spine fixation device	12.58	NA	6.69	2.04	NA	21.31	ZZZ
22843	.....	A	Insert spine fixation device	13.46	NA	6.78	2.10	NA	22.34	ZZZ
22844	.....	A	Insert spine fixation device	16.44	NA	8.99	2.42	NA	27.85	ZZZ
22845	.....	A	Insert spine fixation device	11.96	NA	6.24	2.22	NA	20.42	ZZZ
22846	.....	A	Insert spine fixation device	12.42	NA	6.51	2.26	NA	21.19	ZZZ
22847	.....	A	Insert spine fixation device	13.80	NA	7.21	2.36	NA	23.37	ZZZ
22848	.....	A	Insert pelv fixation device	6.00	NA	3.27	0.88	NA	10.15	ZZZ

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
22849	.....	A	Reinsert spinal fixation	18.51	NA	13.75	2.87	NA	35.13	090
22850	.....	A	Remove spine fixation device	9.52	NA	8.50	1.51	NA	19.53	090
22851	.....	A	Apply spine prosth device	6.71	NA	3.45	1.11	NA	11.27	ZZZ
22852	.....	A	Remove spine fixation device	9.01	NA	8.26	1.40	NA	18.67	090
22855	.....	A	Remove spine fixation device	15.13	NA	11.24	2.74	NA	29.11	090
22899	.....	C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900	.....	A	Remove abdominal wall lesion	5.80	NA	4.29	0.58	NA	10.67	090
22999	.....	C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000	.....	A	Removal of calcium deposits	4.36	8.97	7.38	0.50	13.83	12.24	090
23020	.....	A	Release shoulder joint	8.93	NA	10.95	1.23	NA	21.11	090
23030	.....	A	Drain shoulder lesion	3.43	6.24	4.54	0.42	10.09	8.39	010
23031	.....	A	Drain shoulder bursa	2.74	6.00	4.34	0.33	9.07	7.41	010
23035	.....	A	Drain shoulder bone lesion	8.61	NA	15.81	1.19	NA	25.61	090
23040	.....	A	Exploratory shoulder surgery	9.20	NA	12.15	1.28	NA	22.63	090
23044	.....	A	Exploratory shoulder surgery	7.12	NA	11.01	0.97	NA	19.10	090
23065	.....	A	Biopsy shoulder tissues	2.27	2.71	1.33	0.14	5.12	3.74	010
23066	.....	A	Biopsy shoulder tissues	4.16	7.96	6.49	0.50	12.62	11.15	090
23075	.....	A	Removal of shoulder lesion	2.39	5.36	3.21	0.25	8.00	5.85	010
23076	.....	A	Removal of shoulder lesion	7.63	NA	8.42	0.87	NA	16.92	090
23077	.....	A	Remove tumor of shoulder	16.09	NA	14.26	1.81	NA	32.16	090
23100	.....	A	Biopsy of shoulder joint	6.03	NA	9.13	0.81	NA	15.97	090
23101	.....	A	Shoulder joint surgery	5.58	NA	9.14	0.77	NA	15.49	090
23105	.....	A	Remove shoulder joint lining	8.23	NA	10.55	1.13	NA	19.91	090
23106	.....	A	Incision of collarbone joint	5.96	NA	9.25	0.82	NA	16.03	090
23107	.....	A	Explore treat shoulder joint	8.62	NA	10.74	1.19	NA	20.55	090
23120	.....	A	Partial removal, collar bone	7.11	NA	9.97	0.99	NA	18.07	090
23125	.....	A	Removal of collar bone	9.39	NA	11.08	1.27	NA	21.74	090
23130	.....	A	Remove shoulder bone, part	7.55	NA	10.20	1.06	NA	18.81	090
23140	.....	A	Removal of bone lesion	6.89	NA	8.64	0.82	NA	16.35	090
23145	.....	A	Removal of bone lesion	9.09	NA	12.05	1.24	NA	22.38	090
23146	.....	A	Removal of bone lesion	7.83	NA	11.37	1.11	NA	20.31	090
23150	.....	A	Removal of humerus lesion	8.48	NA	10.37	1.14	NA	19.99	090
23155	.....	A	Removal of humerus lesion	10.35	NA	12.62	1.20	NA	24.17	090
23156	.....	A	Removal of humerus lesion	8.68	NA	10.74	1.18	NA	20.60	090
23170	.....	A	Remove collar bone lesion	6.86	NA	11.17	0.84	NA	18.87	090
23172	.....	A	Remove shoulder blade lesion	6.90	NA	10.70	0.95	NA	18.55	090
23174	.....	A	Remove humerus lesion	9.51	NA	12.19	1.30	NA	23.00	090
23180	.....	A	Remove collar bone lesion	8.53	NA	16.82	1.18	NA	26.53	090
23182	.....	A	Remove shoulder blade lesion	8.15	NA	16.90	1.08	NA	26.13	090
23184	.....	A	Remove humerus lesion	9.38	NA	17.08	1.24	NA	27.70	090
23190	.....	A	Partial removal of scapula	7.24	NA	8.72	0.97	NA	16.93	090
23195	.....	A	Removal of head of humerus	9.81	NA	11.11	1.38	NA	22.30	090
23200	.....	A	Removal of collar bone	12.08	NA	14.52	1.48	NA	28.08	090
23210	.....	A	Removal of shoulder blade	12.49	NA	14.47	1.61	NA	28.57	090
23220	.....	A	Partial removal of humerus	14.56	NA	15.73	2.03	NA	32.32	090
23221	.....	A	Partial removal of humerus	17.74	NA	17.13	2.51	NA	37.38	090
23222	.....	A	Partial removal of humerus	23.92	NA	21.02	3.37	NA	48.31	090
23330	.....	A	Remove shoulder foreign body	1.85	5.75	3.77	0.18	7.78	5.80	010
23331	.....	A	Remove shoulder foreign body	7.38	NA	10.06	1.02	NA	18.46	090
23332	.....	A	Remove shoulder foreign body	11.62	NA	12.40	1.62	NA	25.64	090
23350	.....	A	Injection for shoulder x-ray	1.00	7.30	0.34	0.05	8.35	1.39	000
23395	.....	A	Muscle transfer,shoulder/arm	16.85	NA	14.27	2.29	NA	33.41	090
23397	.....	A	Muscle transfers	16.13	NA	14.61	2.24	NA	32.98	090
23400	.....	A	Fixation of shoulder blade	13.54	NA	14.58	1.91	NA	30.03	090
23405	.....	A	Incision of tendon & muscle	8.37	NA	9.69	1.12	NA	19.18	090
23406	.....	A	Incise tendon(s) & muscle(s)	10.79	NA	11.89	1.48	NA	24.16	090
23410	.....	A	Repair rotator cuff, acute	12.45	NA	12.81	1.72	NA	26.98	090
23412	.....	A	Repair rotator cuff, chronic	13.31	NA	13.32	1.86	NA	28.49	090
23415	.....	A	Release of shoulder ligament	9.97	NA	10.45	1.39	NA	21.81	090
23420	.....	A	Repair of shoulder	13.30	NA	14.31	1.86	NA	29.47	090
23430	.....	A	Repair biceps tendon	9.98	NA	11.50	1.40	NA	22.88	090
23440	.....	A	Remove/transplant tendon	10.48	NA	11.82	1.47	NA	23.77	090
23450	.....	A	Repair shoulder capsule	13.40	NA	13.30	1.86	NA	28.56	090
23455	.....	A	Repair shoulder capsule	14.37	NA	13.88	2.01	NA	30.26	090
23460	.....	A	Repair shoulder capsule	15.37	NA	14.46	2.17	NA	32.00	090
23462	.....	A	Repair shoulder capsule	15.30	NA	14.13	2.16	NA	31.59	090
23465	.....	A	Repair shoulder capsule	15.85	NA	14.31	1.61	NA	31.77	090
23466	.....	A	Repair shoulder capsule	14.22	NA	13.84	2.00	NA	30.06	090
23470	.....	A	Reconstruct shoulder joint	17.15	NA	12.42	2.40	NA	31.97	090
23472	.....	A	Reconstruct shoulder joint	21.10	NA	14.64	2.37	NA	38.11	090
23480	.....	A	Revision of collar bone	11.18	NA	12.16	1.56	NA	24.90	090
23485	.....	A	Revision of collar bone	13.43	NA	13.35	1.84	NA	28.62	090
23490	.....	A	Reinforce clavicle	11.86	NA	12.24	1.11	NA	25.21	090
23491	.....	A	Reinforce shoulder bones	14.21	NA	13.76	2.00	NA	29.97	090
23500	.....	A	Treat clavicle fracture	2.08	4.08	2.60	0.26	6.42	4.94	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
23505	.....	A	Treat clavicle fracture	3.69	6.20	4.12	0.50	10.39	8.31	090
23515	.....	A	Treat clavicle fracture	7.41	NA	8.43	1.03	NA	16.87	090
23520	.....	A	Treat clavicle dislocation	2.16	4.12	2.68	0.26	6.54	5.10	090
23525	.....	A	Treat clavicle dislocation	3.60	6.00	3.98	0.44	10.04	8.02	090
23530	.....	A	Treat clavicle dislocation	7.31	NA	8.20	0.85	NA	16.36	090
23532	.....	A	Treat clavicle dislocation	8.01	NA	8.60	1.13	NA	17.74	090
23540	.....	A	Treat clavicle dislocation	2.23	4.68	2.57	0.24	7.15	5.04	090
23545	.....	A	Treat clavicle dislocation	3.25	5.26	3.69	0.39	8.90	7.33	090
23550	.....	A	Treat clavicle dislocation	7.24	NA	8.37	0.94	NA	16.55	090
23552	.....	A	Treat clavicle dislocation	8.45	NA	9.03	1.18	NA	18.66	090
23570	.....	A	Treat shoulder blade fx	2.23	4.06	2.77	0.29	6.58	5.29	090
23575	.....	A	Treat shoulder blade fx	4.06	6.41	4.37	0.53	11.00	8.96	090
23585	.....	A	Treat scapula fracture	8.96	NA	9.58	1.25	NA	19.79	090
23600	.....	A	Treat humerus fracture	2.93	5.91	3.74	0.39	9.23	7.06	090
23605	.....	A	Treat humerus fracture	4.87	8.79	6.83	0.67	14.33	12.37	090
23615	.....	A	Treat humerus fracture	9.35	NA	10.47	1.31	NA	21.13	090
23616	.....	A	Treat humerus fracture	21.27	NA	16.24	2.98	NA	40.49	090
23620	.....	A	Treat humerus fracture	2.40	5.62	3.47	0.32	8.34	6.19	090
23625	.....	A	Treat humerus fracture	3.93	7.75	5.75	0.53	12.21	10.21	090
23630	.....	A	Treat humerus fracture	7.35	NA	8.44	1.03	NA	16.82	090
23650	.....	A	Treat shoulder dislocation	3.39	5.74	3.58	0.31	9.44	7.28	090
23655	.....	A	Treat shoulder dislocation	4.57	NA	4.38	0.52	NA	9.47	090
23660	.....	A	Treat shoulder dislocation	7.49	NA	8.24	1.01	NA	16.74	090
23665	.....	A	Treat dislocation/fracture	4.47	7.93	5.99	0.60	13.00	11.06	090
23670	.....	A	Treat dislocation/fracture	7.90	NA	8.93	1.10	NA	17.93	090
23675	.....	A	Treat dislocation/fracture	6.05	8.66	6.87	0.83	15.54	13.75	090
23680	.....	A	Treat dislocation/fracture	10.06	NA	10.06	1.39	NA	21.51	090
23700	.....	A	Fixation of shoulder	2.52	NA	3.65	0.35	NA	6.52	010
23800	.....	A	Fusion of shoulder joint	14.16	NA	14.66	1.97	NA	30.79	090
23802	.....	A	Fusion of shoulder joint	16.60	NA	13.91	2.34	NA	32.85	090
23900	.....	A	Amputation of arm & girdle	19.72	NA	15.69	2.47	NA	37.88	090
23920	.....	A	Amputation at shoulder joint	14.61	NA	14.02	1.92	NA	30.55	090
23921	.....	A	Amputation follow-up surgery	5.49	NA	6.90	0.78	NA	13.17	090
23929	.....	C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930	.....	A	Drainage of arm lesion	2.94	6.19	4.05	0.32	9.45	7.31	010
23931	.....	A	Drainage of arm bursa	1.79	5.97	3.88	0.21	7.97	5.88	010
23935	.....	A	Drain arm/elbow bone lesion	6.09	NA	13.61	0.84	NA	20.54	090
24000	.....	A	Exploratory elbow surgery	5.82	NA	6.17	0.77	NA	12.76	090
24006	.....	A	Release elbow joint	9.31	NA	8.70	1.27	NA	19.28	090
24065	.....	A	Biopsy arm/elbow soft tissue	2.08	5.87	3.35	0.14	8.09	5.57	010
24066	.....	A	Biopsy arm/elbow soft tissue	5.21	8.94	6.82	0.61	14.76	12.64	090
24075	.....	A	Remove arm/elbow lesion	3.92	8.20	6.14	0.43	12.55	10.49	090
24076	.....	A	Remove arm/elbow lesion	6.30	NA	7.34	0.70	NA	14.34	090
24077	.....	A	Remove tumor of arm/elbow	11.76	NA	13.78	1.32	NA	26.86	090
24100	.....	A	Biopsy elbow joint lining	4.93	NA	5.79	0.62	NA	11.34	090
24101	.....	A	Explore/treat elbow joint	6.13	NA	6.96	0.84	NA	13.93	090
24102	.....	A	Remove elbow joint lining	8.03	NA	7.95	1.09	NA	17.07	090
24105	.....	A	Removal of elbow bursa	3.61	NA	5.38	0.49	NA	9.48	090
24110	.....	A	Remove humerus lesion	7.39	NA	10.13	0.99	NA	18.51	090
24115	.....	A	Remove/graft bone lesion	9.63	NA	10.52	1.15	NA	21.30	090
24116	.....	A	Remove/graft bone lesion	11.81	NA	12.57	1.66	NA	26.04	090
24120	.....	A	Remove elbow lesion	6.65	NA	6.95	0.87	NA	14.47	090
24125	.....	A	Remove/graft bone lesion	7.89	NA	7.28	0.88	NA	16.05	090
24126	.....	A	Remove/graft bone lesion	8.31	NA	8.03	0.90	NA	17.24	090
24130	.....	A	Removal of head of radius	6.25	NA	7.05	0.87	NA	14.17	090
24134	.....	A	Removal of arm bone lesion	9.73	NA	16.46	1.31	NA	27.50	090
24136	.....	A	Remove radius bone lesion	7.99	NA	6.55	0.85	NA	15.39	090
24138	.....	A	Remove elbow bone lesion	8.05	NA	8.03	1.12	NA	17.20	090
24140	.....	A	Partial removal of arm bone	9.18	NA	17.56	1.23	NA	27.97	090
24145	.....	A	Partial removal of radius	7.58	NA	11.64	1.01	NA	20.23	090
24147	.....	A	Partial removal of elbow	7.54	NA	11.64	1.04	NA	20.22	090
24149	.....	A	Radical resection of elbow	14.20	NA	11.19	1.90	NA	27.29	090
24150	.....	A	Extensive humerus surgery	13.27	NA	15.23	1.81	NA	30.31	090
24151	.....	A	Extensive humerus surgery	15.58	NA	16.96	2.19	NA	34.73	090
24152	.....	A	Extensive radius surgery	10.06	NA	9.83	1.19	NA	21.08	090
24153	.....	A	Extensive radius surgery	11.54	NA	7.06	0.64	NA	19.24	090
24155	.....	A	Removal of elbow joint	11.73	NA	9.42	1.42	NA	22.57	090
24160	.....	A	Remove elbow joint implant	7.83	NA	6.95	1.07	NA	15.85	090
24164	.....	A	Remove radius head implant	6.23	NA	5.95	0.84	NA	13.02	090
24200	.....	A	Removal of arm foreign body	1.76	5.73	3.35	0.15	7.64	5.26	010
24201	.....	A	Removal of arm foreign body	4.56	8.91	7.06	0.56	14.03	12.18	090
24220	.....	A	Injection for elbow x-ray	1.31	11.02	0.46	0.07	12.40	1.84	000
24300	.....	A	Manipulate elbow w/anesth	3.75	NA	5.53	0.49	NA	9.77	090
24301	.....	A	Muscle/tendon transfer	10.20	NA	9.22	1.30	NA	20.72	090
24305	.....	A	Arm tendon lengthening	7.45	NA	7.79	0.98	NA	16.22	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
24310	.....	A	Revision of arm tendon	5.98	NA	8.53	0.74	NA	15.25	090
24320	.....	A	Repair of arm tendon	10.56	NA	11.05	1.00	NA	22.61	090
24330	.....	A	Revision of arm muscles	9.60	NA	8.87	1.21	NA	19.68	090
24331	.....	A	Revision of arm muscles	10.65	NA	9.48	1.41	NA	21.54	090
24332	.....	A	Tenolysis, triceps	7.45	NA	5.21	0.77	NA	13.43	090
24340	.....	A	Repair of biceps tendon	7.89	NA	7.86	1.08	NA	16.83	090
24341	.....	A	Repair arm tendon/muscle	7.90	NA	7.86	1.08	NA	16.84	090
24342	.....	A	Repair of ruptured tendon	10.62	NA	9.44	1.48	NA	21.54	090
24343	.....	A	Repr elbow lat ligmnt w/tiss	8.65	NA	7.89	1.13	NA	17.67	090
24344	.....	A	Reconstruct elbow lat ligmnt	14.00	NA	11.18	1.83	NA	27.01	090
24345	.....	A	Repr elbw med ligmnt w/tissu	8.65	NA	7.89	1.13	NA	17.67	090
24346	.....	A	Reconstruct elbow med ligmnt	14.00	NA	11.18	1.83	NA	27.01	090
24350	.....	A	Repair of tennis elbow	5.25	NA	6.44	0.72	NA	12.41	090
24351	.....	A	Repair of tennis elbow	5.91	NA	6.93	0.82	NA	13.66	090
24352	.....	A	Repair of tennis elbow	6.43	NA	7.19	0.90	NA	14.52	090
24354	.....	A	Repair of tennis elbow	6.48	NA	7.15	0.88	NA	14.51	090
24356	.....	A	Revision of tennis elbow	6.68	NA	7.33	0.90	NA	14.91	090
24360	.....	A	Reconstruct elbow joint	12.34	NA	9.65	1.69	NA	23.68	090
24361	.....	A	Reconstruct elbow joint	14.08	NA	10.64	1.95	NA	26.67	090
24362	.....	A	Reconstruct elbow joint	14.99	NA	12.41	1.92	NA	29.32	090
24363	.....	A	Replace elbow joint	18.49	NA	11.53	2.52	NA	32.54	090
24365	.....	A	Reconstruct head of radius	8.39	NA	7.31	1.11	NA	16.81	090
24366	.....	A	Reconstruct head of radius	9.13	NA	7.69	1.28	NA	18.10	090
24400	.....	A	Revision of humerus	11.06	NA	12.99	1.53	NA	25.58	090
24410	.....	A	Revision of humerus	14.82	NA	14.11	1.89	NA	30.82	090
24420	.....	A	Revision of humerus	13.44	NA	17.27	1.82	NA	32.53	090
24430	.....	A	Repair of humerus	12.81	NA	13.18	1.80	NA	27.79	090
24435	.....	A	Repair humerus with graft	13.17	NA	14.37	1.84	NA	29.38	090
24470	.....	A	Revision of elbow joint	8.74	NA	8.50	1.23	NA	18.47	090
24495	.....	A	Decompression of forearm	8.12	NA	10.28	0.92	NA	19.32	090
24498	.....	A	Reinforce humerus	11.92	NA	12.68	1.67	NA	26.27	090
24500	.....	A	Treat humerus fracture	3.21	5.31	3.38	0.41	8.93	7.00	090
24505	.....	A	Treat humerus fracture	5.17	9.31	7.10	0.72	15.20	12.99	090
24515	.....	A	Treat humerus fracture	11.65	NA	11.58	1.63	NA	24.86	090
24516	.....	A	Treat humerus fracture	11.65	NA	12.14	1.63	NA	25.42	090
24530	.....	A	Treat humerus fracture	3.50	6.52	4.97	0.47	10.49	8.94	090
24535	.....	A	Treat humerus fracture	6.87	9.14	6.89	0.96	16.97	14.72	090
24538	.....	A	Treat humerus fracture	9.43	NA	10.85	1.25	NA	21.53	090
24545	.....	A	Treat humerus fracture	10.46	NA	10.37	1.47	NA	22.30	090
24546	.....	A	Treat humerus fracture	15.69	NA	13.83	2.18	NA	31.70	090
24560	.....	A	Treat humerus fracture	2.80	5.10	3.16	0.35	8.25	6.31	090
24565	.....	A	Treat humerus fracture	5.56	8.24	6.05	0.74	14.54	12.35	090
24566	.....	A	Treat humerus fracture	7.79	NA	10.34	1.10	NA	19.23	090
24575	.....	A	Treat humerus fracture	10.66	NA	8.43	1.44	NA	20.53	090
24576	.....	A	Treat humerus fracture	2.86	4.85	3.31	0.38	8.09	6.55	090
24577	.....	A	Treat humerus fracture	5.79	8.47	6.32	0.81	15.07	12.92	090
24579	.....	A	Treat humerus fracture	11.60	NA	11.31	1.62	NA	24.53	090
24582	.....	A	Treat humerus fracture	8.55	NA	10.77	1.20	NA	20.52	090
24586	.....	A	Treat elbow fracture	15.21	NA	11.05	2.12	NA	28.38	090
24587	.....	A	Treat elbow fracture	15.16	NA	10.88	2.14	NA	28.18	090
24600	.....	A	Treat elbow dislocation	4.23	7.12	5.11	0.49	11.84	9.83	090
24605	.....	A	Treat elbow dislocation	5.42	NA	5.09	0.72	NA	11.23	090
24615	.....	A	Treat elbow dislocation	9.42	NA	7.97	1.31	NA	18.70	090
24620	.....	A	Treat elbow fracture	6.98	NA	6.71	0.90	NA	14.59	090
24635	.....	A	Treat elbow fracture	13.19	NA	16.64	1.84	NA	31.67	090
24640	.....	A	Treat elbow dislocation	1.20	3.54	1.84	0.11	4.85	3.15	010
24650	.....	A	Treat radius fracture	2.16	4.81	2.92	0.28	7.25	5.36	090
24655	.....	A	Treat radius fracture	4.40	7.66	5.41	0.58	12.64	10.39	090
24665	.....	A	Treat radius fracture	8.14	NA	9.72	1.13	NA	18.99	090
24666	.....	A	Treat radius fracture	9.49	NA	10.48	1.32	NA	21.29	090
24670	.....	A	Treat ulnar fracture	2.54	4.71	3.13	0.33	7.58	6.00	090
24675	.....	A	Treat ulnar fracture	4.72	7.86	5.68	0.65	13.23	11.05	090
24685	.....	A	Treat ulnar fracture	8.80	NA	10.08	1.23	NA	20.11	090
24800	.....	A	Fusion of elbow joint	11.20	NA	9.94	1.41	NA	22.55	090
24802	.....	A	Fusion/graft of elbow joint	13.69	NA	11.56	1.89	NA	27.14	090
24900	.....	A	Amputation of upper arm	9.60	NA	11.21	1.18	NA	21.99	090
24920	.....	A	Amputation of upper arm	9.54	NA	12.82	1.22	NA	23.58	090
24925	.....	A	Amputation follow-up surgery	7.07	NA	9.68	0.95	NA	17.70	090
24930	.....	A	Amputation follow-up surgery	10.25	NA	11.78	1.23	NA	23.26	090
24931	.....	A	Amputate upper arm & implant	12.72	NA	9.23	1.56	NA	23.51	090
24935	.....	A	Revision of amputation	15.56	NA	12.63	1.58	NA	29.77	090
24940	.....	C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999	.....	C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000	.....	A	Incision of tendon sheath	3.38	NA	7.59	0.45	NA	11.42	090
25001	.....	A	Incise flexor carpi radialis	3.38	NA	4.37	0.45	NA	8.20	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
25020	.....	A	Decompress forearm 1 space	5.92	NA	11.38	0.76	NA	18.06	090
25023	.....	A	Decompress forearm 1 space	12.96	NA	17.36	1.52	NA	31.84	090
25024	.....	A	Decompress forearm 2 spaces	9.50	NA	8.08	1.24	NA	18.82	090
25025	.....	A	Decompress forarm 2 spaces	16.54	NA	11.75	2.18	NA	30.47	090
25028	.....	A	Drainage of forearm lesion	5.25	NA	10.17	0.61	NA	16.03	090
25031	.....	A	Drainage of forearm bursa	4.14	NA	10.14	0.50	NA	14.78	090
25035	.....	A	Treat forearm bone lesion	7.36	NA	16.87	0.98	NA	25.21	090
25040	.....	A	Explore/treat wrist joint	7.18	NA	9.48	0.96	NA	17.62	090
25065	.....	A	Biopsy forearm soft tissues	1.99	2.58	2.58	0.12	4.69	4.69	010
25066	.....	A	Biopsy forearm soft tissues	4.13	NA	8.42	0.49	NA	13.04	090
25075	.....	A	Removel forearm lesion subcu	3.74	NA	7.39	0.40	NA	11.53	090
25076	.....	A	Removel forearm lesion deep	4.92	NA	12.88	0.59	NA	18.39	090
25077	.....	A	Remove tumor, forearm/wrist	9.76	NA	15.51	1.10	NA	26.37	090
25085	.....	A	Incision of wrist capsule	5.50	NA	11.29	0.71	NA	17.50	090
25100	.....	A	Biopsy of wrist joint	3.90	NA	7.66	0.50	NA	12.06	090
25101	.....	A	Explore/treat wrist joint	4.69	NA	8.02	0.60	NA	13.31	090
25105	.....	A	Remove wrist joint lining	5.85	NA	11.25	0.77	NA	17.87	090
25107	.....	A	Remove wrist joint cartilage	6.43	NA	11.62	0.82	NA	18.87	090
25110	.....	A	Remove wrist tendon lesion	3.92	NA	8.62	0.48	NA	13.02	090
25111	.....	A	Remove wrist tendon lesion	3.39	NA	6.67	0.42	NA	10.48	090
25112	.....	A	Reremove wrist tendon lesion	4.53	NA	7.49	0.54	NA	12.56	090
25115	.....	A	Remove wrist/forearm lesion	8.82	NA	17.36	1.11	NA	27.29	090
25116	.....	A	Remove wrist/forearm lesion	7.11	NA	16.36	0.90	NA	24.37	090
25118	.....	A	Excise wrist tendon sheath	4.37	NA	8.09	0.55	NA	13.01	090
25119	.....	A	Partial removal of ulna	6.04	NA	11.54	0.80	NA	18.38	090
25120	.....	A	Removal of forearm lesion	6.10	NA	15.31	0.81	NA	22.22	090
25125	.....	A	Remove/graft forearm lesion	7.48	NA	16.39	1.02	NA	24.89	090
25126	.....	A	Remove/graft forearm lesion	7.55	NA	15.93	1.00	NA	24.48	090
25130	.....	A	Removal of wrist lesion	5.26	NA	8.44	0.66	NA	14.36	090
25135	.....	A	Remove & graft wrist lesion	6.89	NA	9.27	0.89	NA	17.05	090
25136	.....	A	Remove & graft wrist lesion	5.97	NA	8.50	0.58	NA	15.05	090
25145	.....	A	Remove forearm bone lesion	6.37	NA	15.73	0.82	NA	22.92	090
25150	.....	A	Partial removal of ulna	7.09	NA	12.28	0.96	NA	20.33	090
25151	.....	A	Partial removal of radius	7.39	NA	16.28	0.93	NA	24.60	090
25170	.....	A	Extensive forearm surgery	11.09	NA	17.76	1.52	NA	30.37	090
25210	.....	A	Removal of wrist bone	5.95	NA	8.84	0.73	NA	15.52	090
25215	.....	A	Removal of wrist bones	7.89	NA	12.52	1.02	NA	21.43	090
25230	.....	A	Partial removal of radius	5.23	NA	8.35	0.66	NA	14.24	090
25240	.....	A	Partial removal of ulna	5.17	NA	11.07	0.69	NA	16.93	090
25246	.....	A	Injection for wrist x-ray	1.45	10.27	0.50	0.07	11.79	2.02	000
25248	.....	A	Remove forearm foreign body	5.14	NA	10.23	0.54	NA	15.91	090
25250	.....	A	Removal of wrist prosthesis	6.60	NA	6.19	0.84	NA	13.63	090
25251	.....	A	Removal of wrist prosthesis	9.57	NA	8.08	1.15	NA	18.80	090
25259	.....	A	Manipulate wrist w/anesthes	3.75	NA	5.46	0.50	NA	9.71	090
25260	.....	A	Repair forearm tendon/muscle	7.80	NA	17.12	0.97	NA	25.89	090
25263	.....	A	Repair forearm tendon/muscle	7.82	NA	16.99	0.94	NA	25.75	090
25265	.....	A	Repair forearm tendon/muscle	9.88	NA	17.71	1.19	NA	28.78	090
25270	.....	A	Repair forearm tendon/muscle	6.00	NA	16.17	0.76	NA	22.93	090
25272	.....	A	Repair forearm tendon/muscle	7.04	NA	16.74	0.89	NA	24.67	090
25274	.....	A	Repair forearm tendon/muscle	8.75	NA	17.17	1.14	NA	27.06	090
25275	.....	A	Repair forearm tendon sheath	8.50	NA	7.44	1.13	NA	17.07	090
25280	.....	A	Revise wrist/forearm tendon	7.22	NA	16.29	0.91	NA	24.42	090
25290	.....	A	Incise wrist/forearm tendon	5.29	NA	18.62	0.66	NA	24.57	090
25295	.....	A	Release wrist/forearm tendon	6.55	NA	15.93	0.86	NA	23.34	090
25300	.....	A	Fusion of tendons at wrist	8.80	NA	10.06	1.07	NA	19.93	090
25301	.....	A	Fusion of tendons at wrist	8.40	NA	9.98	1.08	NA	19.46	090
25310	.....	A	Transplant forearm tendon	8.14	NA	16.74	1.01	NA	25.89	090
25312	.....	A	Transplant forearm tendon	9.57	NA	17.49	1.22	NA	28.28	090
25315	.....	A	Revise palsy hand tendon(s)	10.20	NA	18.31	1.26	NA	29.77	090
25316	.....	A	Revise palsy hand tendon(s)	12.33	NA	19.71	1.74	NA	33.78	090
25320	.....	A	Repair/revise wrist joint	10.77	NA	11.50	1.32	NA	23.59	090
25332	.....	A	Revise wrist joint	11.41	NA	9.34	1.46	NA	22.21	090
25335	.....	A	Realignment of hand	12.88	NA	14.95	1.66	NA	29.49	090
25337	.....	A	Reconstruct ulna/radioulnar	10.17	NA	13.85	1.31	NA	25.33	090
25350	.....	A	Revision of radius	8.78	NA	16.98	1.17	NA	26.93	090
25355	.....	A	Revision of radius	10.17	NA	17.60	1.44	NA	29.21	090
25360	.....	A	Revision of ulna	8.43	NA	16.89	1.17	NA	26.49	090
25365	.....	A	Revise radius & ulna	12.40	NA	18.51	1.67	NA	32.58	090
25370	.....	A	Revise radius or ulna	13.36	NA	18.42	1.88	NA	33.66	090
25375	.....	A	Revise radius & ulna	13.04	NA	19.42	1.84	NA	34.30	090
25390	.....	A	Shorten radius or ulna	10.40	NA	17.69	1.38	NA	29.47	090
25391	.....	A	Lengthen radius or ulna	13.65	NA	19.37	1.73	NA	34.75	090
25392	.....	A	Shorten radius & ulna	13.95	NA	18.37	1.73	NA	34.05	090
25393	.....	A	Lengthen radius & ulna	15.87	NA	20.63	1.87	NA	38.37	090
25394	.....	A	Repair carpal bone, shorten	10.40	NA	8.29	1.40	NA	20.09	090

[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
25400	.....	A	Repair radius or ulna	10.92	NA	18.22	1.50	NA	30.64	090
25405	.....	A	Repair/graft radius or ulna	14.38	NA	20.48	1.95	NA	36.81	090
25415	.....	A	Repair radius & ulna	13.35	NA	19.39	1.87	NA	34.61	090
25420	.....	A	Repair/graft radius & ulna	16.33	NA	21.34	2.20	NA	39.87	090
25425	.....	A	Repair/graft radius or ulna	13.21	NA	26.80	1.61	NA	41.62	090
25426	.....	A	Repair/graft radius & ulna	15.82	NA	20.12	2.23	NA	38.17	090
25430	.....	A	Vasc graft into carpal bone	9.25	NA	7.62	1.07	NA	17.94	090
25431	.....	A	Repair nonunion carpal bone	10.44	NA	6.38	0.56	NA	17.38	090
25440	.....	A	Repair/graft wrist bone	10.44	NA	11.25	1.41	NA	23.10	090
25441	.....	A	Reconstruct wrist joint	12.90	NA	10.14	1.83	NA	24.87	090
25442	.....	A	Reconstruct wrist joint	10.85	NA	9.00	1.24	NA	21.09	090
25443	.....	A	Reconstruct wrist joint	10.39	NA	8.89	1.30	NA	20.58	090
25444	.....	A	Reconstruct wrist joint	11.15	NA	9.17	1.43	NA	21.75	090
25445	.....	A	Reconstruct wrist joint	9.69	NA	8.18	1.26	NA	19.13	090
25446	.....	A	Wrist replacement	16.55	NA	12.17	2.20	NA	30.92	090
25447	.....	A	Repair wrist joint(s)	10.37	NA	8.76	1.34	NA	20.47	090
25449	.....	A	Remove wrist joint implant	14.49	NA	10.89	1.77	NA	27.15	090
25450	.....	A	Revision of wrist joint	7.87	NA	13.09	0.88	NA	21.84	090
25455	.....	A	Revision of wrist joint	9.49	NA	14.28	1.07	NA	24.84	090
25490	.....	A	Reinforce radius	9.54	NA	16.71	1.19	NA	27.44	090
25491	.....	A	Reinforce ulna	9.96	NA	17.58	1.41	NA	28.95	090
25492	.....	A	Reinforce radius and ulna	12.33	NA	18.06	1.62	NA	32.01	090
25500	.....	A	Treat fracture of radius	2.45	4.37	2.93	0.28	7.10	5.66	090
25505	.....	A	Treat fracture of radius	5.21	8.04	5.81	0.69	13.94	11.71	090
25515	.....	A	Treat fracture of radius	9.18	NA	10.00	1.22	NA	20.40	090
25520	.....	A	Treat fracture of radius	6.26	8.23	6.43	0.85	15.34	13.54	090
25525	.....	A	Treat fracture of radius	12.24	NA	11.92	1.68	NA	25.84	090
25526	.....	A	Treat fracture of radius	12.98	NA	15.40	1.80	NA	30.18	090
25530	.....	A	Treat fracture of ulna	2.09	4.42	2.92	0.27	6.78	5.28	090
25535	.....	A	Treat fracture of ulna	5.14	7.81	5.86	0.68	13.63	11.68	090
25545	.....	A	Treat fracture of ulna	8.90	NA	10.14	1.23	NA	20.27	090
25560	.....	A	Treat fracture radius & ulna	2.44	4.41	2.90	0.27	7.12	5.61	090
25565	.....	A	Treat fracture radius & ulna	5.63	8.28	6.02	0.76	14.67	12.41	090
25574	.....	A	Treat fracture radius & ulna	7.01	NA	9.05	0.96	NA	17.02	090
25575	.....	A	Treat fracture radius/ulna	10.45	NA	10.98	1.46	NA	22.89	090
25600	.....	A	Treat fracture radius/ulna	2.63	4.75	3.11	0.34	7.72	6.08	090
25605	.....	A	Treat fracture radius/ulna	5.81	8.51	6.27	0.81	15.13	12.89	090
25611	.....	A	Treat fracture radius/ulna	7.77	NA	10.37	1.08	NA	19.22	090
25620	.....	A	Treat fracture radius/ulna	8.55	NA	9.91	1.17	NA	19.63	090
25622	.....	A	Treat wrist bone fracture	2.61	4.70	3.08	0.33	7.64	6.02	090
25624	.....	A	Treat wrist bone fracture	4.53	7.73	5.49	0.61	12.87	10.63	090
25628	.....	A	Treat wrist bone fracture	8.43	NA	9.95	1.14	NA	19.52	090
25630	.....	A	Treat wrist bone fracture	2.88	4.86	3.14	0.37	8.11	6.39	090
25635	.....	A	Treat wrist bone fracture	4.39	7.68	4.75	0.39	12.46	9.53	090
25645	.....	A	Treat wrist bone fracture	7.25	NA	9.47	0.93	NA	17.65	090
25650	.....	A	Treat wrist bone fracture	3.05	4.91	3.21	0.37	8.33	6.63	090
25651	.....	A	Pin ulnar styloid fracture	5.36	NA	5.69	0.72	NA	11.77	090
25652	.....	A	Treat fracture ulnar styloid	7.60	NA	6.85	1.02	NA	15.47	090
25660	.....	A	Treat wrist dislocation	4.76	NA	5.49	0.59	NA	10.84	090
25670	.....	A	Treat wrist dislocation	7.92	NA	9.73	1.07	NA	18.72	090
25671	.....	A	Pin radioulnar dislocation	6.00	NA	6.02	0.81	NA	12.83	090
25675	.....	A	Treat wrist dislocation	4.67	7.52	5.43	0.57	12.76	10.67	090
25676	.....	A	Treat wrist dislocation	8.04	NA	9.78	1.10	NA	18.92	090
25680	.....	A	Treat wrist fracture	5.99	NA	6.48	0.61	NA	13.08	090
25685	.....	A	Treat wrist fracture	9.78	NA	10.44	1.25	NA	21.47	090
25690	.....	A	Treat wrist dislocation	5.50	NA	7.21	0.78	NA	13.49	090
25695	.....	A	Treat wrist dislocation	8.34	NA	9.86	1.07	NA	19.27	090
25800	.....	A	Fusion of wrist joint	9.76	NA	10.92	1.30	NA	21.98	090
25805	.....	A	Fusion/graft of wrist joint	11.28	NA	11.81	1.51	NA	24.60	090
25810	.....	A	Fusion/graft of wrist joint	10.57	NA	11.34	1.37	NA	23.28	090
25820	.....	A	Fusion of hand bones	7.45	NA	9.68	0.96	NA	18.09	090
25825	.....	A	Fuse hand bones with graft	9.27	NA	10.66	1.20	NA	21.13	090
25830	.....	A	Fusion, radioulnar jnt/ulna	10.06	NA	17.12	1.27	NA	28.45	090
25900	.....	A	Amputation of forearm	9.01	NA	14.48	1.08	NA	24.57	090
25905	.....	A	Amputation of forearm	9.12	NA	15.75	1.06	NA	25.93	090
25907	.....	A	Amputation follow-up surgery	7.80	NA	15.19	1.01	NA	24.00	090
25909	.....	A	Amputation follow-up surgery	8.96	NA	15.62	1.07	NA	25.65	090
25915	.....	A	Amputation of forearm	17.08	NA	23.14	2.41	NA	42.63	090
25920	.....	A	Amputate hand at wrist	8.68	NA	9.91	1.06	NA	19.65	090
25922	.....	A	Amputate hand at wrist	7.42	NA	9.06	0.93	NA	17.41	090
25924	.....	A	Amputation follow-up surgery	8.46	NA	10.25	1.07	NA	19.78	090
25927	.....	A	Amputation of hand	8.80	NA	14.18	1.02	NA	24.00	090
25929	.....	A	Amputation follow-up surgery	7.59	NA	7.83	0.89	NA	16.31	090
25931	.....	A	Amputation follow-up surgery	7.81	NA	15.09	0.88	NA	23.78	090
25999	.....	C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
26010	.....	A	Drainage of finger abscess	1.54	5.97	1.78	0.14	7.65	3.46	010
26011	.....	A	Drainage of finger abscess	2.19	12.48	2.48	0.25	14.92	4.92	010
26020	.....	A	Drain hand tendon sheath	4.67	NA	5.31	0.59	NA	10.57	090
26025	.....	A	Drainage of palm bursa	4.82	NA	5.18	0.60	NA	10.60	090
26030	.....	A	Drainage of palm bursa(s)	5.93	NA	5.85	0.72	NA	12.50	090
26034	.....	A	Treat hand bone lesion	6.23	NA	6.04	0.79	NA	13.06	090
26035	.....	A	Decompress fingers/hand	9.51	NA	7.99	1.12	NA	18.62	090
26037	.....	A	Decompress fingers/hand	7.25	NA	6.48	0.87	NA	14.60	090
26040	.....	A	Release palm contracture	3.33	NA	3.75	0.45	NA	7.53	090
26045	.....	A	Release palm contracture	5.56	NA	5.30	0.74	NA	11.60	090
26055	.....	A	Incise finger tendon sheath	2.69	15.46	3.59	0.36	18.51	6.64	090
26060	.....	A	Incision of finger tendon	2.81	NA	3.28	0.35	NA	6.44	090
26070	.....	A	Explore/treat hand joint	3.69	NA	3.32	0.35	NA	7.36	090
26075	.....	A	Explore/treat finger joint	3.79	NA	3.67	0.40	NA	7.86	090
26080	.....	A	Explore/treat finger joint	4.24	NA	4.58	0.52	NA	9.34	090
26100	.....	A	Biopsy hand joint lining	3.67	NA	3.90	0.45	NA	8.02	090
26105	.....	A	Biopsy finger joint lining	3.71	NA	3.93	0.45	NA	8.09	090
26110	.....	A	Biopsy finger joint lining	3.53	NA	3.80	0.44	NA	7.77	090
26115	.....	A	Removel hand lesion subcut	3.86	14.42	4.43	0.48	18.76	8.77	090
26116	.....	A	Removel hand lesion, deep	5.53	NA	5.66	0.69	NA	11.88	090
26117	.....	A	Remove tumor, hand/finger	8.55	NA	6.94	1.01	NA	16.50	090
26121	.....	A	Release palm contracture	7.54	NA	6.72	0.94	NA	15.20	090
26123	.....	A	Release palm contracture	9.29	NA	8.65	1.17	NA	19.11	090
26125	.....	A	Release palm contracture	4.61	NA	2.51	0.57	NA	7.69	ZZZ
26130	.....	A	Remove wrist joint lining	5.42	NA	5.12	0.65	NA	11.19	090
26135	.....	A	Revise finger joint, each	6.96	NA	6.20	0.87	NA	14.03	090
26140	.....	A	Revise finger joint, each	6.17	NA	5.75	0.76	NA	12.68	090
26145	.....	A	Tendon excision, palm/finger	6.32	NA	5.78	0.77	NA	12.87	090
26160	.....	A	Remove tendon sheath lesion	3.15	18.94	3.86	0.39	22.48	7.40	090
26170	.....	A	Removal of palm tendon, each	4.77	NA	4.72	0.60	NA	10.09	090
26180	.....	A	Removal of finger tendon	5.18	NA	5.10	0.64	NA	10.92	090
26185	.....	A	Remove finger bone	5.25	NA	5.62	0.67	NA	11.54	090
26200	.....	A	Remove hand bone lesion	5.51	NA	5.14	0.71	NA	11.36	090
26205	.....	A	Remove/graft bone lesion	7.70	NA	6.69	0.95	NA	15.34	090
26210	.....	A	Removal of finger lesion	5.15	NA	5.12	0.64	NA	10.91	090
26215	.....	A	Remove/graft finger lesion	7.10	NA	6.07	0.77	NA	13.94	090
26230	.....	A	Partial removal of hand bone	6.33	NA	5.68	0.84	NA	12.85	090
26235	.....	A	Partial removal, finger bone	6.19	NA	5.62	0.78	NA	12.59	090
26236	.....	A	Partial removal, finger bone	5.32	NA	5.17	0.66	NA	11.15	090
26250	.....	A	Extensive hand surgery	7.55	NA	6.23	0.92	NA	14.70	090
26255	.....	A	Extensive hand surgery	12.43	NA	9.26	1.05	NA	22.74	090
26260	.....	A	Extensive finger surgery	7.03	NA	5.98	0.83	NA	13.84	090
26261	.....	A	Extensive finger surgery	9.09	NA	6.22	0.84	NA	16.15	090
26262	.....	A	Partial removal of finger	5.67	NA	5.18	0.70	NA	11.55	090
26320	.....	A	Removal of implant from hand	3.98	NA	4.50	0.49	NA	8.97	090
26340	.....	A	Manipulate finger w/anesth	2.50	NA	4.64	0.30	NA	7.44	090
26350	.....	A	Repair finger/hand tendon	5.99	NA	20.03	0.73	NA	26.75	090
26352	.....	A	Repair/graft hand tendon	7.68	NA	20.50	0.93	NA	29.11	090
26356	.....	A	Repair finger/hand tendon	8.07	NA	21.49	0.99	NA	30.55	090
26357	.....	A	Repair finger/hand tendon	8.58	NA	21.19	1.02	NA	30.79	090
26358	.....	A	Repair/graft hand tendon	9.14	NA	21.74	1.07	NA	31.95	090
26370	.....	A	Repair finger/hand tendon	7.11	NA	20.67	0.90	NA	28.68	090
26372	.....	A	Repair/graft hand tendon	8.76	NA	22.00	1.06	NA	31.82	090
26373	.....	A	Repair finger/hand tendon	8.16	NA	21.56	0.98	NA	30.70	090
26390	.....	A	Revise hand/finger tendon	9.19	NA	16.75	1.09	NA	27.03	090
26392	.....	A	Repair/graft hand tendon	10.26	NA	22.55	1.26	NA	34.07	090
26410	.....	A	Repair hand tendon	4.63	NA	16.30	0.57	NA	21.50	090
26412	.....	A	Repair/graft hand tendon	6.31	NA	17.39	0.80	NA	24.50	090
26415	.....	A	Excision, hand/finger tendon	8.34	NA	15.90	0.77	NA	25.01	090
26416	.....	A	Graft hand or finger tendon	9.37	NA	18.56	1.20	NA	29.13	090
26418	.....	A	Repair finger tendon	4.25	NA	16.13	0.50	NA	20.88	090
26420	.....	A	Repair/graft finger tendon	6.77	NA	17.69	0.83	NA	25.29	090
26426	.....	A	Repair finger/hand tendon	6.15	NA	17.16	0.77	NA	24.08	090
26428	.....	A	Repair/graft finger tendon	7.21	NA	18.24	0.84	NA	26.29	090
26432	.....	A	Repair finger tendon	4.02	NA	13.36	0.48	NA	17.86	090
26433	.....	A	Repair finger tendon	4.56	NA	14.27	0.56	NA	19.39	090
26434	.....	A	Repair/graft finger tendon	6.09	NA	14.67	0.71	NA	21.47	090
26437	.....	A	Realignment of tendons	5.82	NA	14.40	0.74	NA	20.96	090
26440	.....	A	Release palm/finger tendon	5.02	NA	18.87	0.62	NA	24.51	090
26442	.....	A	Release palm & finger tendon	8.16	NA	20.31	0.94	NA	29.41	090
26445	.....	A	Release hand/finger tendon	4.31	NA	18.71	0.54	NA	23.56	090
26449	.....	A	Release forearm/hand tendon	7.00	NA	20.02	0.84	NA	27.86	090
26450	.....	A	Incision of palm tendon	3.67	NA	8.57	0.46	NA	12.70	090
26455	.....	A	Incision of finger tendon	3.64	NA	8.45	0.47	NA	12.56	090
26460	.....	A	Incise hand/finger tendon	3.46	NA	8.20	0.44	NA	12.10	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
26471	.....	A	Fusion of finger tendons	5.73	NA	14.06	0.73	NA	20.52	090
26474	.....	A	Fusion of finger tendons	5.32	NA	14.31	0.69	NA	20.32	090
26476	.....	A	Tendon lengthening	5.18	NA	13.80	0.62	NA	19.60	090
26477	.....	A	Tendon shortening	5.15	NA	14.01	0.60	NA	19.76	090
26478	.....	A	Lengthening of hand tendon	5.80	NA	14.65	0.77	NA	21.22	090
26479	.....	A	Shortening of hand tendon	5.74	NA	14.65	0.76	NA	21.15	090
26480	.....	A	Transplant hand tendon	6.69	NA	19.94	0.84	NA	27.47	090
26483	.....	A	Transplant/graft hand tendon	8.29	NA	20.43	1.03	NA	29.75	090
26485	.....	A	Transplant palm tendon	7.70	NA	20.34	0.94	NA	28.98	090
26489	.....	A	Transplant/graft palm tendon	9.55	NA	17.04	0.98	NA	27.57	090
26490	.....	A	Revise thumb tendon	8.41	NA	15.54	1.05	NA	25.00	090
26492	.....	A	Tendon transfer with graft	9.62	NA	16.15	1.19	NA	26.96	090
26494	.....	A	Hand tendon/muscle transfer	8.47	NA	16.14	1.13	NA	25.74	090
26496	.....	A	Revise thumb tendon	9.59	NA	15.87	1.17	NA	26.63	090
26497	.....	A	Finger tendon transfer	9.57	NA	16.32	1.17	NA	27.06	090
26498	.....	A	Finger tendon transfer	14.00	NA	18.71	1.74	NA	34.45	090
26499	.....	A	Revision of finger	8.98	NA	17.02	0.94	NA	26.94	090
26500	.....	A	Hand tendon reconstruction	5.96	NA	14.98	0.66	NA	21.60	090
26502	.....	A	Hand tendon reconstruction	7.14	NA	15.27	0.87	NA	23.28	090
26504	.....	A	Hand tendon reconstruction	7.47	NA	15.08	0.84	NA	23.39	090
26508	.....	A	Release thumb contracture	6.01	NA	14.59	0.76	NA	21.36	090
26510	.....	A	Thumb tendon transfer	5.43	NA	14.30	0.71	NA	20.44	090
26516	.....	A	Fusion of knuckle joint	7.15	NA	15.07	0.90	NA	23.12	090
26517	.....	A	Fusion of knuckle joints	8.83	NA	16.41	0.96	NA	26.20	090
26518	.....	A	Fusion of knuckle joints	9.02	NA	16.12	1.13	NA	26.27	090
26520	.....	A	Release knuckle contracture	5.30	NA	18.85	0.65	NA	24.80	090
26525	.....	A	Release finger contracture	5.33	NA	19.02	0.66	NA	25.01	090
26530	.....	A	Revise knuckle joint	6.69	NA	6.04	0.86	NA	13.59	090
26531	.....	A	Revise knuckle with implant	7.91	NA	6.95	1.01	NA	15.87	090
26535	.....	A	Revise finger joint	5.24	NA	3.69	0.66	NA	9.59	090
26536	.....	A	Revise/implant finger joint	6.37	NA	10.32	0.80	NA	17.49	090
26540	.....	A	Repair hand joint	6.43	NA	14.89	0.81	NA	22.13	090
26541	.....	A	Repair hand joint with graft	8.62	NA	16.25	1.12	NA	25.99	090
26542	.....	A	Repair hand joint with graft	6.78	NA	14.78	0.87	NA	22.43	090
26545	.....	A	Reconstruct finger joint	6.92	NA	15.52	0.79	NA	23.23	090
26546	.....	A	Repair nonunion hand	8.92	NA	16.15	1.14	NA	26.21	090
26548	.....	A	Reconstruct finger joint	8.03	NA	16.02	0.98	NA	25.03	090
26550	.....	A	Construct thumb replacement	21.24	NA	23.47	1.80	NA	46.51	090
26551	.....	A	Great toe-hand transfer	46.58	NA	36.90	6.57	NA	90.05	090
26553	.....	A	Single transfer, toe-hand	46.27	NA	28.16	1.99	NA	76.42	090
26554	.....	A	Double transfer, toe-hand	54.95	NA	38.79	7.76	NA	101.50	090
26555	.....	A	Positional change of finger	16.63	NA	22.51	2.13	NA	41.27	090
26556	.....	A	Toe joint transfer	47.26	NA	34.27	6.67	NA	88.20	090
26560	.....	A	Repair of web finger	5.38	NA	12.99	0.60	NA	18.97	090
26561	.....	A	Repair of web finger	10.92	NA	16.12	0.69	NA	27.73	090
26562	.....	A	Repair of web finger	15.00	NA	19.37	0.98	NA	35.35	090
26565	.....	A	Correct metacarpal flaw	6.74	NA	14.95	0.84	NA	22.53	090
26567	.....	A	Correct finger deformity	6.82	NA	14.88	0.84	NA	22.54	090
26568	.....	A	Lengthen metacarpal/finger	9.08	NA	20.41	1.10	NA	30.59	090
26580	.....	A	Repair hand deformity	18.18	NA	15.87	1.46	NA	35.51	090
26587	.....	A	Reconstruct extra finger	14.05	6.36	NA	1.12	21.53	NA	090
26590	.....	A	Repair finger deformity	17.96	NA	17.46	1.32	NA	36.74	090
26591	.....	A	Repair muscles of hand	3.25	NA	13.80	0.37	NA	17.42	090
26593	.....	A	Release muscles of hand	5.31	NA	13.78	0.64	NA	19.73	090
26596	.....	A	Excision constricting tissue	8.95	NA	9.86	0.87	NA	19.68	090
26600	.....	A	Treat metacarpal fracture	1.96	4.36	2.83	0.25	6.57	5.04	090
26605	.....	A	Treat metacarpal fracture	2.85	6.33	4.45	0.38	9.56	7.68	090
26607	.....	A	Treat metacarpal fracture	5.36	NA	8.46	0.70	NA	14.52	090
26608	.....	A	Treat metacarpal fracture	5.36	NA	9.07	0.73	NA	15.16	090
26615	.....	A	Treat metacarpal fracture	5.33	NA	8.49	0.70	NA	14.52	090
26641	.....	A	Treat thumb dislocation	3.94	6.70	4.86	0.42	11.06	9.22	090
26645	.....	A	Treat thumb fracture	4.41	7.51	5.35	0.54	12.46	10.30	090
26650	.....	A	Treat thumb fracture	5.72	NA	9.24	0.77	NA	15.73	090
26665	.....	A	Treat thumb fracture	7.60	NA	9.52	0.97	NA	18.09	090
26670	.....	A	Treat hand dislocation	3.69	6.53	4.75	0.36	10.58	8.80	090
26675	.....	A	Treat hand dislocation	4.64	6.66	4.57	0.56	11.86	9.77	090
26676	.....	A	Pin hand dislocation	5.52	NA	9.30	0.76	NA	15.58	090
26685	.....	A	Treat hand dislocation	6.98	NA	9.14	0.95	NA	17.07	090
26686	.....	A	Treat hand dislocation	7.94	NA	9.73	1.05	NA	18.72	090
26700	.....	A	Treat knuckle dislocation	3.69	5.13	2.96	0.35	9.17	7.00	090
26705	.....	A	Treat knuckle dislocation	4.19	6.47	4.41	0.50	11.16	9.10	090
26706	.....	A	Pin knuckle dislocation	5.12	NA	5.98	0.64	NA	11.74	090
26715	.....	A	Treat knuckle dislocation	5.74	NA	8.65	0.75	NA	15.14	090
26720	.....	A	Treat finger fracture, each	1.66	3.22	1.69	0.20	5.08	3.55	090
26725	.....	A	Treat finger fracture, each	3.33	5.47	3.28	0.43	9.23	7.04	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
26727	.....	A	Treat finger fracture, each	5.23	NA	9.18	0.69	NA	15.10	090
26735	.....	A	Treat finger fracture, each	5.98	NA	8.91	0.77	NA	15.66	090
26740	.....	A	Treat finger fracture, each	1.94	4.01	2.67	0.24	6.19	4.85	090
26742	.....	A	Treat finger fracture, each	3.85	7.41	5.28	0.49	11.75	9.62	090
26746	.....	A	Treat finger fracture, each	5.81	NA	8.98	0.74	NA	15.53	090
26750	.....	A	Treat finger fracture, each	1.70	3.82	2.41	0.19	5.71	4.30	090
26755	.....	A	Treat finger fracture, each	3.10	5.25	3.10	0.37	8.72	6.57	090
26756	.....	A	Pin finger fracture, each	4.39	NA	8.89	0.56	NA	13.84	090
26765	.....	A	Treat finger fracture, each	4.17	NA	7.97	0.51	NA	12.65	090
26770	.....	A	Treat finger dislocation	3.02	4.98	2.71	0.27	8.27	6.00	090
26775	.....	A	Treat finger dislocation	3.71	6.25	4.06	0.43	10.39	8.20	090
26776	.....	A	Pin finger dislocation	4.80	NA	9.01	0.63	NA	14.44	090
26785	.....	A	Treat finger dislocation	4.21	NA	7.94	0.54	NA	12.69	090
26820	.....	A	Thumb fusion with graft	8.26	NA	16.22	1.11	NA	25.59	090
26841	.....	A	Fusion of thumb	7.13	NA	15.46	0.97	NA	23.56	090
26842	.....	A	Thumb fusion with graft	8.24	NA	16.24	1.10	NA	25.58	090
26843	.....	A	Fusion of hand joint	7.61	NA	14.93	0.99	NA	23.53	090
26844	.....	A	Fusion/graft of hand joint	8.73	NA	16.20	1.12	NA	26.05	090
26850	.....	A	Fusion of knuckle	6.97	NA	14.89	0.89	NA	22.75	090
26852	.....	A	Fusion of knuckle with graft	8.46	NA	15.84	1.05	NA	25.35	090
26860	.....	A	Fusion of finger joint	4.69	NA	13.75	0.60	NA	19.04	090
26861	.....	A	Fusion of finger jnt, add-on	1.74	NA	0.96	0.22	NA	2.92	ZZZ
26862	.....	A	Fusion/graft of finger joint	7.37	NA	15.38	0.92	NA	23.67	090
26863	.....	A	Fuse/graft added joint	3.90	NA	2.17	0.51	NA	6.58	ZZZ
26910	.....	A	Amputate metacarpal bone	7.60	NA	14.07	0.90	NA	22.57	090
26951	.....	A	Amputation of finger/thumb	4.59	NA	13.06	0.56	NA	18.21	090
26952	.....	A	Amputation of finger/thumb	6.31	NA	14.25	0.74	NA	21.30	090
26989	.....	C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990	.....	A	Drainage of pelvis lesion	7.48	NA	16.35	0.92	NA	24.75	090
26991	.....	A	Drainage of pelvis bursa	6.68	11.94	9.87	0.85	19.47	17.40	090
26992	.....	A	Drainage of bone lesion	13.02	NA	20.25	1.75	NA	35.02	090
27000	.....	A	Incision of hip tendon	5.62	NA	7.78	0.76	NA	14.16	090
27001	.....	A	Incision of hip tendon	6.94	NA	8.52	0.95	NA	16.41	090
27003	.....	A	Incision of hip tendon	7.34	NA	9.52	0.93	NA	17.79	090
27005	.....	A	Incision of hip tendon	9.66	NA	10.84	1.36	NA	21.86	090
27006	.....	A	Incision of hip tendons	9.68	NA	10.84	1.33	NA	21.85	090
27025	.....	A	Incision of hip/thigh fascia	11.16	NA	10.70	1.38	NA	23.24	090
27030	.....	A	Drainage of hip joint	13.01	NA	12.69	1.81	NA	27.51	090
27033	.....	A	Exploration of hip joint	13.39	NA	12.81	1.87	NA	28.07	090
27035	.....	A	Denervation of hip joint	16.69	NA	17.51	1.70	NA	35.90	090
27036	.....	A	Excision of hip joint/muscle	12.88	NA	14.25	1.80	NA	28.93	090
27040	.....	A	Biopsy of soft tissues	2.87	6.16	3.97	0.21	9.24	7.05	010
27041	.....	A	Biopsy of soft tissues	9.89	NA	8.60	1.01	NA	19.50	090
27047	.....	A	Remove hip/pelvis lesion	7.45	9.54	7.15	0.79	17.78	15.39	090
27048	.....	A	Remove hip/pelvis lesion	6.25	NA	8.06	0.73	NA	15.04	090
27049	.....	A	Remove tumor, hip/pelvis	13.66	NA	13.54	1.60	NA	28.80	090
27050	.....	A	Biopsy of sacroiliac joint	4.36	NA	7.42	0.53	NA	12.31	090
27052	.....	A	Biopsy of hip joint	6.23	NA	8.71	0.85	NA	15.79	090
27054	.....	A	Removal of hip joint lining	8.54	NA	11.05	1.17	NA	20.76	090
27060	.....	A	Removal of ischial bursa	5.43	NA	7.63	0.60	NA	13.66	090
27062	.....	A	Remove femur lesion/bursa	5.37	NA	7.59	0.74	NA	13.70	090
27065	.....	A	Removal of hip bone lesion	5.90	NA	9.09	0.76	NA	15.75	090
27066	.....	A	Removal of hip bone lesion	10.33	NA	12.88	1.42	NA	24.63	090
27067	.....	A	Remove/graft hip bone lesion	13.83	NA	14.91	1.95	NA	30.69	090
27070	.....	A	Partial removal of hip bone	10.72	NA	18.36	1.36	NA	30.44	090
27071	.....	A	Partial removal of hip bone	11.46	NA	19.32	1.51	NA	32.29	090
27075	.....	A	Extensive hip surgery	35.00	NA	25.82	2.22	NA	63.04	090
27076	.....	A	Extensive hip surgery	22.12	NA	20.29	2.86	NA	45.27	090
27077	.....	A	Extensive hip surgery	40.00	NA	29.14	3.18	NA	72.32	090
27078	.....	A	Extensive hip surgery	13.44	NA	15.81	1.67	NA	30.92	090
27079	.....	A	Extensive hip surgery	13.75	NA	15.34	1.86	NA	30.95	090
27080	.....	A	Removal of tail bone	6.39	NA	7.66	0.80	NA	14.85	090
27086	.....	A	Remove hip foreign body	1.87	5.13	3.97	0.17	7.17	6.01	010
27087	.....	A	Remove hip foreign body	8.54	NA	9.19	1.09	NA	18.82	090
27090	.....	A	Removal of hip prosthesis	11.15	NA	8.95	1.55	NA	21.65	090
27091	.....	A	Removal of hip prosthesis	22.14	NA	14.22	3.11	NA	39.47	090
27093	.....	A	Injection for hip x-ray	1.30	12.50	0.50	0.09	13.89	1.89	000
27095	.....	A	Injection for hip x-ray	1.50	11.47	0.54	0.10	13.07	2.14	000
27096	.....	A	Inject sacroiliac joint	1.40	10.28	0.34	0.08	11.76	1.82	000
27097	.....	A	Revision of hip tendon	8.80	NA	9.44	1.22	NA	19.46	090
27098	.....	A	Transfer tendon to pelvis	8.83	NA	9.88	1.24	NA	19.95	090
27100	.....	A	Transfer of abdominal muscle	11.08	NA	13.03	1.57	NA	25.68	090
27105	.....	A	Transfer of spinal muscle	11.77	NA	12.72	1.66	NA	26.15	090
27110	.....	A	Transfer of iliopsoas muscle	13.26	NA	13.59	1.38	NA	28.23	090
27111	.....	A	Transfer of iliopsoas muscle	12.15	NA	12.43	1.48	NA	26.06	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
27120	.....	A	Reconstruction of hip socket	18.01	NA	12.05	2.45	NA	32.51	090
27122	.....	A	Reconstruction of hip socket	14.98	NA	11.19	2.08	NA	28.25	090
27125	.....	A	Partial hip replacement	14.69	NA	10.75	2.05	NA	27.49	090
27130	.....	A	Total hip arthroplasty	20.12	NA	13.58	2.82	NA	36.52	090
27132	.....	A	Total hip arthroplasty	23.30	NA	15.87	3.26	NA	42.43	090
27134	.....	A	Revise hip joint replacement	28.52	NA	18.20	3.97	NA	50.69	090
27137	.....	A	Revise hip joint replacement	21.17	NA	14.24	2.97	NA	38.38	090
27138	.....	A	Revise hip joint replacement	22.17	NA	14.72	3.11	NA	40.00	090
27140	.....	A	Transplant femur ridge	12.24	NA	12.27	1.67	NA	26.18	090
27146	.....	A	Incision of hip bone	17.43	NA	16.51	2.27	NA	36.21	090
27147	.....	A	Revision of hip bone	20.58	NA	17.71	2.61	NA	40.90	090
27151	.....	A	Incision of hip bones	22.51	NA	12.83	3.12	NA	38.46	090
27156	.....	A	Revision of hip bones	24.63	NA	20.37	3.48	NA	48.48	090
27158	.....	A	Revision of pelvis	19.74	NA	16.00	2.60	NA	38.34	090
27161	.....	A	Incision of neck of femur	16.71	NA	14.57	2.32	NA	33.60	090
27165	.....	A	Incision/fixation of femur	17.91	NA	15.11	2.51	NA	35.53	090
27170	.....	A	Repair/graft femur head/neck	16.07	NA	14.30	2.20	NA	32.57	090
27175	.....	A	Treat slipped epiphysis	8.46	NA	7.39	1.19	NA	17.04	090
27176	.....	A	Treat slipped epiphysis	12.05	NA	10.20	1.68	NA	23.93	090
27177	.....	A	Treat slipped epiphysis	15.08	NA	11.88	2.11	NA	29.07	090
27178	.....	A	Treat slipped epiphysis	11.99	NA	9.63	1.68	NA	23.30	090
27179	.....	A	Revise head/neck of femur	12.98	NA	11.01	1.84	NA	25.83	090
27181	.....	A	Treat slipped epiphysis	14.68	NA	11.17	1.74	NA	27.59	090
27185	.....	A	Revision of femur epiphysis	9.18	NA	10.51	1.29	NA	20.98	090
27187	.....	A	Reinforce hip bones	13.54	NA	13.81	1.89	NA	29.24	090
27193	.....	A	Treat pelvic ring fracture	5.56	7.39	5.47	0.77	13.72	11.80	090
27194	.....	A	Treat pelvic ring fracture	9.65	9.40	7.71	1.32	20.37	18.68	090
27200	.....	A	Treat tail bone fracture	1.84	3.25	1.83	0.22	5.31	3.89	090
27202	.....	A	Treat tail bone fracture	7.04	NA	22.21	0.69	NA	29.94	090
27215	.....	A	Treat pelvic fracture(s)	10.05	NA	10.59	1.37	NA	22.01	090
27216	.....	A	Treat pelvic ring fracture	15.19	NA	14.82	2.15	NA	32.16	090
27217	.....	A	Treat pelvic ring fracture	14.11	NA	13.07	1.95	NA	29.13	090
27218	.....	A	Treat pelvic ring fracture	20.15	NA	14.41	2.85	NA	37.41	090
27220	.....	A	Treat hip socket fracture	6.18	7.73	5.82	0.85	14.76	12.85	090
27222	.....	A	Treat hip socket fracture	12.70	NA	10.44	1.77	NA	24.91	090
27226	.....	A	Treat hip wall fracture	14.91	NA	10.98	2.07	NA	27.96	090
27227	.....	A	Treat hip fracture(s)	23.45	NA	17.40	3.24	NA	44.09	090
27228	.....	A	Treat hip fracture(s)	27.16	NA	19.68	3.77	NA	50.61	090
27230	.....	A	Treat thigh fracture	5.50	8.01	6.44	0.73	14.24	12.67	090
27232	.....	A	Treat thigh fracture	10.68	NA	9.48	1.45	NA	21.61	090
27235	.....	A	Treat thigh fracture	12.16	NA	11.34	1.71	NA	25.21	090
27236	.....	A	Treat thigh fracture	15.60	NA	11.28	2.18	NA	29.06	090
27238	.....	A	Treat thigh fracture	5.52	NA	6.55	0.76	NA	12.83	090
27240	.....	A	Treat thigh fracture	12.50	NA	10.52	1.69	NA	24.71	090
27244	.....	A	Treat thigh fracture	15.94	NA	13.24	2.23	NA	31.41	090
27245	.....	A	Treat thigh fracture	20.31	NA	15.64	2.85	NA	38.80	090
27246	.....	A	Treat thigh fracture	4.71	7.73	6.19	0.66	13.10	11.56	090
27248	.....	A	Treat thigh fracture	10.45	NA	10.25	1.45	NA	22.15	090
27250	.....	A	Treat hip dislocation	6.95	NA	6.49	0.68	NA	14.12	090
27252	.....	A	Treat hip dislocation	10.39	NA	8.43	1.37	NA	20.19	090
27253	.....	A	Treat hip dislocation	12.92	NA	11.14	1.81	NA	25.87	090
27254	.....	A	Treat hip dislocation	18.26	NA	14.04	2.52	NA	34.82	090
27256	.....	A	Treat hip dislocation	4.12	NA	4.45	0.49	NA	9.06	010
27257	.....	A	Treat hip dislocation	5.22	NA	4.77	0.56	NA	10.55	010
27258	.....	A	Treat hip dislocation	15.43	NA	14.26	2.06	NA	31.75	090
27259	.....	A	Treat hip dislocation	21.55	NA	17.51	2.99	NA	42.05	090
27265	.....	A	Treat hip dislocation	5.05	NA	6.25	0.65	NA	11.95	090
27266	.....	A	Treat hip dislocation	7.49	NA	7.69	1.04	NA	16.22	090
27275	.....	A	Manipulation of hip joint	2.27	NA	3.75	0.31	NA	6.33	010
27280	.....	A	Fusion of sacroiliac joint	13.39	NA	14.60	1.98	NA	29.97	090
27282	.....	A	Fusion of pubic bones	11.34	NA	12.54	1.14	NA	25.02	090
27284	.....	A	Fusion of hip joint	23.45	NA	18.80	2.36	NA	44.61	090
27286	.....	A	Fusion of hip joint	23.45	NA	19.33	2.37	NA	45.15	090
27290	.....	A	Amputation of leg at hip	23.28	NA	17.03	2.94	NA	43.25	090
27295	.....	A	Amputation of leg at hip	18.65	NA	14.46	2.35	NA	35.46	090
27299	.....	C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301	.....	A	Drain thigh/knee lesion	6.49	16.43	14.49	0.80	23.72	21.78	090
27303	.....	A	Drainage of bone lesion	8.28	NA	15.57	1.14	NA	24.99	090
27305	.....	A	Incise thigh tendon & fascia	5.92	NA	9.50	0.77	NA	16.19	090
27306	.....	A	Incision of thigh tendon	4.62	NA	7.93	0.62	NA	13.17	090
27307	.....	A	Incision of thigh tendons	5.80	NA	8.53	0.78	NA	15.11	090
27310	.....	A	Exploration of knee joint	9.27	NA	10.40	1.29	NA	20.96	090
27315	.....	A	Partial removal, thigh nerve	6.97	NA	4.45	0.79	NA	12.21	090
27320	.....	A	Partial removal, thigh nerve	6.30	NA	4.68	0.78	NA	11.76	090
27323	.....	A	Biopsy, thigh soft tissues	2.28	6.01	3.57	0.17	8.46	6.02	010

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs[3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
27324	.....	A	Biopsy, thigh soft tissues	4.90	NA	7.14	0.59	NA	12.63	090
27327	.....	A	Removal of thigh lesion	4.47	8.59	6.51	0.50	13.56	11.48	090
27328	.....	A	Removal of thigh lesion	5.57	NA	7.28	0.66	NA	13.51	090
27329	.....	A	Remove tumor, thigh/knee	14.14	NA	14.74	1.68	NA	30.56	090
27330	.....	A	Biopsy, knee joint lining	4.97	NA	6.61	0.66	NA	12.24	090
27331	.....	A	Explore/treat knee joint	5.88	NA	7.83	0.81	NA	14.52	090
27332	.....	A	Removal of knee cartilage	8.27	NA	9.06	1.15	NA	18.48	090
27333	.....	A	Removal of knee cartilage	7.30	NA	8.59	1.03	NA	16.92	090
27334	.....	A	Remove knee joint lining	8.70	NA	9.97	1.21	NA	19.88	090
27335	.....	A	Remove knee joint lining	10.00	NA	10.83	1.41	NA	22.24	090
27340	.....	A	Removal of kneecap bursa	4.18	NA	6.26	0.58	NA	11.02	090
27345	.....	A	Removal of knee cyst	5.92	NA	7.70	0.81	NA	14.43	090
27347	.....	A	Remove knee cyst	5.78	NA	7.45	0.76	NA	13.99	090
27350	.....	A	Removal of kneecap	8.17	NA	9.17	1.15	NA	18.49	090
27355	.....	A	Remove femur lesion	7.65	NA	10.74	1.07	NA	19.46	090
27356	.....	A	Remove femur lesion/graft	9.48	NA	11.74	1.29	NA	22.51	090
27357	.....	A	Remove femur lesion/graft	10.53	NA	12.24	1.48	NA	24.25	090
27358	.....	A	Remove femur lesion/fixation	4.74	NA	2.59	0.67	NA	8.00	ZZZ
27360	.....	A	Partial removal, leg bone(s)	10.50	NA	18.97	1.42	NA	30.89	090
27365	.....	A	Extensive leg surgery	16.27	NA	14.68	2.26	NA	33.21	090
27370	.....	A	Injection for knee x-ray	0.96	11.98	0.33	0.06	13.00	1.35	000
27372	.....	A	Removal of foreign body	5.07	8.64	6.69	0.62	14.33	12.38	090
27380	.....	A	Repair of kneecap tendon	7.16	NA	8.67	1.00	NA	16.83	090
27381	.....	A	Repair/graft kneecap tendon	10.34	NA	10.37	1.44	NA	22.15	090
27385	.....	A	Repair of thigh muscle	7.76	NA	9.02	1.09	NA	17.87	090
27386	.....	A	Repair/graft of thigh muscle	10.56	NA	11.17	1.49	NA	23.22	090
27390	.....	A	Incision of thigh tendon	5.33	NA	8.20	0.69	NA	14.22	090
27391	.....	A	Incision of thigh tendons	7.20	NA	9.33	0.99	NA	17.52	090
27392	.....	A	Incision of thigh tendons	9.20	NA	11.43	1.23	NA	21.86	090
27393	.....	A	Lengthening of thigh tendon	6.39	NA	8.74	0.90	NA	16.03	090
27394	.....	A	Lengthening of thigh tendons	8.50	NA	11.13	1.17	NA	20.80	090
27395	.....	A	Lengthening of thigh tendons	11.73	NA	14.02	1.63	NA	27.38	090
27396	.....	A	Transplant of thigh tendon	7.86	NA	11.02	1.11	NA	19.99	090
27397	.....	A	Transplants of thigh tendons	11.28	NA	12.48	1.58	NA	25.34	090
27400	.....	A	Revise thigh muscles/tendons	9.02	NA	11.20	1.18	NA	21.40	090
27403	.....	A	Repair of knee cartilage	8.33	NA	9.19	1.16	NA	18.68	090
27405	.....	A	Repair of knee ligament	8.65	NA	10.04	1.21	NA	19.90	090
27407	.....	A	Repair of knee ligament	10.28	NA	10.74	1.38	NA	22.40	090
27409	.....	A	Repair of knee ligaments	12.90	NA	12.29	1.75	NA	26.94	090
27418	.....	A	Repair degenerated kneecap	10.85	NA	11.28	1.51	NA	23.64	090
27420	.....	A	Revision of unstable kneecap	9.83	NA	10.02	1.38	NA	21.23	090
27422	.....	A	Revision of unstable kneecap	9.78	NA	10.04	1.37	NA	21.19	090
27424	.....	A	Revision/removal of kneecap	9.81	NA	10.00	1.38	NA	21.19	090
27425	.....	A	Lat retinacular release open	5.22	NA	7.58	0.73	NA	13.53	090
27427	.....	A	Reconstruction, knee	9.36	NA	9.64	1.29	NA	20.29	090
27428	.....	A	Reconstruction, knee	14.00	NA	12.86	1.95	NA	28.81	090
27429	.....	A	Reconstruction, knee	15.52	NA	13.68	2.18	NA	31.38	090
27430	.....	A	Revision of thigh muscles	9.67	NA	10.08	1.35	NA	21.10	090
27435	.....	A	Incision of knee joint	9.49	NA	9.91	1.33	NA	20.73	090
27437	.....	A	Revise kneecap	8.46	NA	7.31	1.18	NA	16.95	090
27438	.....	A	Revise kneecap with implant	11.23	NA	8.71	1.56	NA	21.50	090
27440	.....	A	Revision of knee joint	10.43	NA	6.23	1.42	NA	18.08	090
27441	.....	A	Revision of knee joint	10.82	NA	6.90	1.49	NA	19.21	090
27442	.....	A	Revision of knee joint	11.89	NA	9.09	1.68	NA	22.66	090
27443	.....	A	Revision of knee joint	10.93	NA	8.85	1.52	NA	21.30	090
27445	.....	A	Revision of knee joint	17.68	NA	12.52	2.49	NA	32.69	090
27446	.....	A	Revision of knee joint	15.84	NA	11.50	2.22	NA	29.56	090
27447	.....	A	Total knee arthroplasty	21.48	NA	14.82	3.00	NA	39.30	090
27448	.....	A	Incision of thigh	11.06	NA	12.41	1.51	NA	24.98	090
27450	.....	A	Incision of thigh	13.98	NA	14.20	1.96	NA	30.14	090
27454	.....	A	Realignment of thigh bone	17.56	NA	16.02	2.46	NA	36.04	090
27455	.....	A	Realignment of knee	12.82	NA	12.70	1.78	NA	27.30	090
27457	.....	A	Realignment of knee	13.45	NA	11.87	1.88	NA	27.20	090
27465	.....	A	Shortening of thigh bone	13.87	NA	14.06	1.86	NA	29.79	090
27466	.....	A	Lengthening of thigh bone	16.33	NA	16.39	1.92	NA	34.64	090
27468	.....	A	Shorten/lengthen thighs	18.97	NA	16.56	2.68	NA	38.21	090
27470	.....	A	Repair of thigh	16.07	NA	16.45	2.24	NA	34.76	090
27472	.....	A	Repair/graft of thigh	17.72	NA	17.33	2.49	NA	37.54	090
27475	.....	A	Surgery to stop leg growth	8.64	NA	9.62	1.13	NA	19.39	090
27477	.....	A	Surgery to stop leg growth	9.85	NA	10.08	1.31	NA	21.24	090
27479	.....	A	Surgery to stop leg growth	12.80	NA	12.35	1.81	NA	26.96	090
27485	.....	A	Surgery to stop leg growth	8.84	NA	9.79	1.24	NA	19.87	090
27486	.....	A	Revise/replace knee joint	19.27	NA	13.67	2.70	NA	35.64	090
27487	.....	A	Revise/replace knee joint	25.27	NA	16.83	3.54	NA	45.64	090
27488	.....	A	Removal of knee prosthesis	15.74	NA	11.83	2.21	NA	29.78	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician Work RVUs [3]	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Non-Facility Total	Facility Total	Global
27495	.....	A	Reinforce thigh	15.55	NA	16.19	2.18	NA	33.92	090
27496	.....	A	Decompression of thigh/knee	6.11	NA	8.25	0.77	NA	15.13	090
27497	.....	A	Decompression of thigh/knee	7.17	NA	8.28	0.84	NA	16.29	090
27498	.....	A	Decompression of thigh/knee	7.99	NA	8.67	0.97	NA	17.63	090
27499	.....	A	Decompression of thigh/knee	9.00	NA	9.28	1.18	NA	19.46	090
27500	.....	A	Treatment of thigh fracture	5.92	10.40	7.84	0.80	17.12	14.56	090
27501	.....	A	Treatment of thigh fracture	5.92	11.65	9.09	0.83	18.40	15.84	090
27502	.....	A	Treatment of thigh fracture	10.58	NA	11.60	1.49	NA	23.67	090
27503	.....	A	Treatment of thigh fracture	10.58	NA	11.64	1.49	NA	23.71	090
27506	.....	A	Treatment of thigh fracture	17.45	NA	14.57	2.33	NA	34.35	090
27507	.....	A	Treatment of thigh fracture	13.99	NA	12.74	1.95	NA	28.68	090
27508	.....	A	Treatment of thigh fracture	5.83	7.42	5.52	0.80	14.05	12.15	090
27509	.....	A	Treatment of thigh fracture	7.71	NA	9.50	1.08	NA	18.29	090
27510	.....	A	Treatment of thigh fracture	9.13	NA	7.39	1.26	NA	17.78	090
27511	.....	A	Treatment of thigh fracture	13.64	NA	13.34	1.91	NA	28.89	090
27513	.....	A	Treatment of thigh fracture	17.92	NA	15.66	2.51	NA	36.09	090
27514	.....	A	Treatment of thigh fracture	17.30	NA	14.78	2.41	NA	34.49	090
27516	.....	A	Treat thigh fx growth plate	5.37	8.20	6.00	0.74	14.31	12.11	090
27517	.....	A	Treat thigh fx growth plate	8.78	9.86	7.97	1.22	19.86	17.97	090
27519	.....	A	Treat thigh fx growth plate	15.02	NA	13.83	2.09	NA	30.94	090
27520	.....	A	Treat kneecap fracture	2.86	5.79	3.90	0.38	9.03	7.14	090
27524	.....	A	Treat kneecap fracture	10.00	NA	9.05	1.40	NA	20.45	090
27530	.....	A	Treat knee fracture	3.78	6.31	4.45	0.51	10.60	8.74	090
27532	.....	A	Treat knee fracture	7.30	7.79	5.87	1.02	16.11	14.19	090
27535	.....	A	Treat knee fracture	11.50	NA	12.23	1.61	NA	25.34	090
27536	.....	A	Treat knee fracture	15.65	NA	12.09	2.19	NA	29.93	090
27538	.....	A	Treat knee fracture(s)	4.87	7.97	5.73	0.67	13.51	11.27	090
27540	.....	A	Treat knee fracture	13.10	NA	10.55	1.80	NA	25.45	090
27550	.....	A	Treat knee dislocation	5.76	7.57	5.83	0.68	14.01	12.27	090
27552	.....	A	Treat knee dislocation	7.90	NA	8.23	1.10	NA	17.23	090
27556	.....	A	Treat knee dislocation	14.41	NA	14.69	2.01	NA	31.11	090
27557	.....	A	Treat knee dislocation	16.77	NA	15.93	2.37	NA	35.07	090
27558	.....	A	Treat knee dislocation	17.72	NA	16.13	2.51	NA	36.36	090
27560	.....	A	Treat kneecap dislocation	3.82	6.20	3.99	0.40	10.42	8.21	090
27562	.....	A	Treat kneecap dislocation	5.79	NA	5.85	0.69	NA	12.33	090
27566	.....	A	Treat kneecap dislocation	12.23	NA	10.20	1.73	NA	24.16	090
27570	.....	A	Fixation of knee joint	1.74	NA	3.45	0.24	NA	5.43	010
27580	.....	A	Fusion of knee	19.37	NA	16.57	2.70	NA	38.64	090
27590	.....	A	Amputate leg at thigh	12.03	NA	12.59	1.35	NA	25.97	090
27591	.....	A	Amputate leg at thigh	12.68	NA	14.63	1.63	NA	28.94	090
27592	.....	A	Amputate leg at thigh	10.02	NA	12.18	1.17	NA	23.37	090
27594	.....	A	Amputation follow-up surgery	6.92	NA	9.10	0.82	NA	16.84	090
27596	.....	A	Amputation follow-up surgery	10.60	NA	12.65	1.24	NA	24.49	090
27598	.....	A	Amputate lower leg at knee	10.53	NA	11.61	1.24	NA	23.38	090
27599	.....	C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600	.....	A	Decompression of lower leg	5.65	NA	7.85	0.68	NA	14.18	090
27601	.....	A	Decompression of lower leg	5.64	NA	7.79	0.69	NA	14.12	090
27602	.....	A	Decompression of lower leg	7.35	NA	8.13	0.85	NA	16.33	090
27603	.....	A	Drain lower leg lesion	4.94	16.03	10.71	0.56	21.53	16.21	090
27604	.....	A	Drain lower leg bursa	4.47	11.74	8.69	0.54	16.75	13.70	090
27605	.....	A	Incision of achilles tendon	2.87	10.88	4.01	0.38	14.13	7.26	010
27606	.....	A	Incision of achilles tendon	4.14	13.17	5.24	0.57	17.88	9.95	010
27607	.....	A	Treat lower leg bone lesion	7.97	NA	14.85	1.08	NA	23.90	090
27610	.....	A	Explore/treat ankle joint	8.34	NA	10.90	1.15	NA	20.39	090
27612	.....	A	Exploration of ankle joint	7.33	NA	8.61	1.01	NA	16.95	090
27613	.....	A	Biopsy lower leg soft tissue	2.17	5.93	3.16	0.16	8.26	5.49	010
27614	.....	A	Biopsy lower leg soft tissue	5.66	11.55	7.39	0.62	17.83	13.67	090
27615	.....	A	Remove tumor, lower leg	12.56	NA	16.85	1.39	NA	30.80	090
27618	.....	A	Remove lower leg lesion	5.09	11.86	6.86	0.54	17.49	12.49	090
27619	.....	A	Remove lower leg lesion	8.40	13.36	9.46	1.01	22.77	18.87	090
27620	.....	A	Explore/treat ankle joint	5.98	NA	8.48	0.83	NA	15.29	090
27625	.....	A	Remove ankle joint lining	8.30	NA	10.10	1.16	NA	19.56	090
27626	.....	A	Remove ankle joint lining	8.91	NA	10.79	1.23	NA	20.93	090
27630	.....	A	Removal of tendon lesion	4.80	11.52	7.24	0.60	16.92	12.64	090
27635	.....	A	Remove lower leg bone lesion	7.78	NA	11.58	1.06	NA	20.42	090
27637	.....	A	Remove/graft leg bone lesion	9.85	NA	12.91	1.38	NA	24.14	090
27638	.....	A	Remove/graft leg bone lesion	10.57	NA	13.24	1.47	NA	25.28	090
27640	.....	A	Partial removal of tibia	11.37	NA	18.94	1.54	NA	31.85	090
27641	.....	A	Partial removal of fibula	9.24	NA	16.89	1.22	NA	27.35	090
27645	.....	A	Extensive lower leg surgery	14.17	NA	18.70	1.98	NA	34.85	090
27646	.....	A	Extensive lower leg surgery	12.66	NA	17.64	1.55	NA	31.85	090
27647	.....	A	Extensive ankle/heel surgery	12.24	NA	11.52	1.64	NA	25.40	090
27648	.....	A	Injection for ankle x-ray	0.96	9.75	0.34	0.05	10.76	1.35	000
27650	.....	A	Repair achilles tendon	9.69	NA	9.79	1.35	NA	20.83	090
27652	.....	A	Repair/graft achilles tendon	10.33	NA	10.02	1.45	NA	21.80	090

[1] CPT codes and descriptions only are copyright 2002 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
[2] Copyright 2002 American Dental Association. All rights reserved.
[3] + Indicates RVUs are not used for Medicare payment.